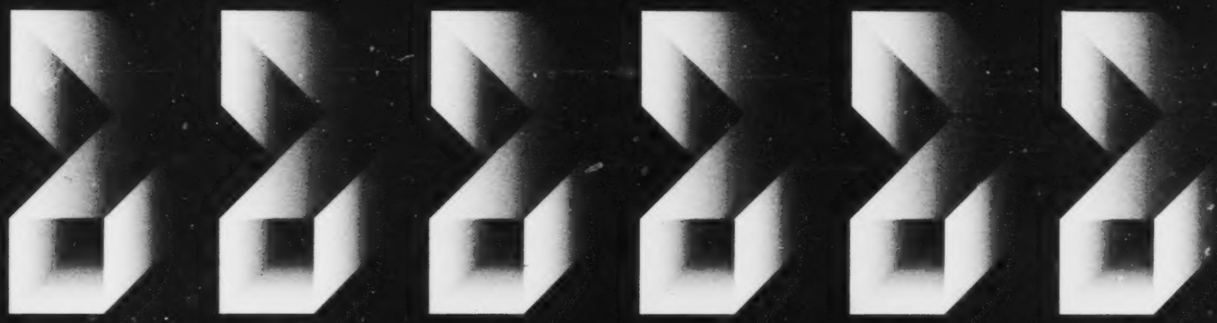
Health Canada Santé Canada

Evaluation Group **Groupe de l'évaluation**

Strategic Planning and Review Directorate **Direction de la planification stratégique et de l'examen**

Policy and Consultation Branch **Direction générale des politiques et de la consultation**



DRAFT

FINAL EVALUATION
NATIONAL AIDS STRATEGY - PHASE II

RESEARCH REPORT #2
EVALUATION OF CSC'S PARTICIPATION IN THE NATIONAL AIDS STRATEGY - PHASE II

September 1997

Canada

MISSION STATEMENT

The Evaluation Group helps Health Canada serve Canadians better by providing objective information and advice about the effectiveness of departmental activities and services.

ÉNONCÉ DE MISSION

Le Groupe de l'évaluation aide Santé Canada à mieux servir les Canadiens et les Canadiennes en offrant une information et des conseils objectifs sur l'efficacité des activités et des services du Ministère.

EVALUATION OF CSC'S PARTICIPATION IN THE

NATIONAL AIDS STRATEGY - PHASE II

Final Draft

Performance Assurance Sector
September 1997

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

ASSESSMENT OF CSC'S PARTICIPATION IN NAS-II v

Relevance and Continued Need v

Implementation and Objectives Achievement vi

Cost-effectiveness and Alternatives ix

SUMMARY AND CONCLUSIONS x

LIST OF RECOMMENDATIONS xi

1. INTRODUCTION 1

1.1 BACKGROUND - NATIONAL AIDS STRATEGY - PHASE II (NAS-II) 1

1.2 CSC'S PARTICIPATION IN NAS-II 2

1.3 EVALUATION OF NAS-II 4

1.4 SCOPE AND FOCUS OF THE STUDY 4

1.5 METHODOLOGY 6

Internal Review 9

File and Document Review 9

Questionnaire - Institutional Chiefs Health Services 10

National Inmate Survey 10

International Comparisons 11

1.6 LIMITATIONS OF THE EVALUATION 11

2. CONTEXT FOR CSC PARTICIPATION IN NAS-II 13

2.1 FEDERAL CORRECTIONS SYSTEM 13

2:2 HEALTH SERVICES IN THE CORRECTIONAL SERVICE OF CANADA 15

2.3 CSC AND HEALTH SERVICES ORGANIZATIONAL STRUCTURE 16

2.4 INCIDENCE OF HIV INFECTION IN CSC INSTITUTIONS 17

2.5 RISK BEHAVIOUR FOR HIV TRANSMISSION IN PRISONS 18

Injection Drug Use 18

Consensual and Non-Consensual Sexual Behaviour 19

Tattooing and Piercing 19

2.6 ENVIRONMENT FOR IMPLEMENTATION OF NAS-II IN CSC 21

CSC Reorganization 21

Management of the Initiative 22

3. CSC ACTIVITIES UNDER NAS-II 24

3.1 OBJECTIVES 24

3.2 ACTIVITIES AND OUTPUTS 24

Policy Development 30

Program Delivery and Evaluation 30

Epidemiologic Monitoring 31

Research and Evaluation 31

Inmate Education 32

Prevention 34

Care, Treatment and Support 34

Staff Education 34

Issue Management 35

Promoting Partnerships: 36

3.3 PLANNED ACTIVITIES 37

4. ASSESSMENT OF CSC'S PARTICIPATION IN THE NAS-II 38

4.1 RELEVANCE AND CONTINUED NEED 38
  Relevance: 38
  Continued Need: 40
  Education and Training of Staff and Inmates. 41
  Expansion of Harm Reduction Measures. 42
  Care, Treatment and Support and Health Promotion Activities. 42
  Research into Seroprevalence. 43
  Addressing the Needs of Special Interest Groups. 44
  Summary and Conclusions 45
4.2 IMPLEMENTATION AND OBJECTIVES ACHIEVEMENT 45
  Impact Analysis of the ECAP Report Recommendations 45
  The Need for an Integrated Corporate Framework, Strategic Approach and Accountability Framework 46
  Coordination and Collaboration 51
  Transferability of Pilot Results 57
  Inconsistent Implementation. 59
    Inmate Education 60
    Staff Education 62
    Professional Staff Training 65
  Adequacy of Resources. 66
  Monitoring and Evaluating the Implementation of the National AIDS Program 69
    Data on Incidence of HIV/AIDS. 70
    Project Monitoring and Evaluation 71
  Summary and Conclusions - Implementation and Objectives Achievement 74
4.3 COST EFFECTIVENESS AND ALTERNATIVES 76
  Summary and Conclusions 78

104-00844/

EXECUTIVE SUMMARY

The Correctional Service of Canada is a participant in the federal National AIDS Strategy - Phase II (NAS-II). This initiative is a continuation of an earlier initiative (NAS). Both initiatives are directed at responding to the issues of HIV/AIDS in Canada. CSC is one of two Departments, external to the lead department - Health Canada, who was allocated funds under NAS-II to work toward the achievement of three main goals. These are:

- to stop the spread of HIV/AIDS;
- to develop more appropriate and effective ways to provide care, treatment and support to people living with HIV/AIDS, their caregivers, families and friends;
- search for effective vaccines, drugs and therapies.

In addition, for the purposes of the evaluation, a fourth goal was added - to implement Phase II effectively.

The Correctional Service was allocated $400,000 per annum under NAS-II. This was subsequently reduced for 1996/97 to $300,000. There were no person years allocated, however, a portion of CSC's funds were used to staff the position of National HIV/AIDS Coordinator and a support position to administer the CSC program.

The Service's involvement in NAS-II arises out of the fact that inmates have been identified as a vulnerable population. Although precise data are not available, evidence suggests that the prevalence of HIV/AIDS in correctional institutions is much higher than in the general population. The only seroprevalence study conducted in a federal facility found the rate of HIV/AIDS to be ten times higher than in the general population. The high seroprevalence rates may be attributed, in part, to the large number of offenders who enter the system with long histories of substance abuse. A history of injection drug use is significantly associated with HIV seroprevalence among offenders.

Transmission of HIV/AIDS and other infectious diseases is poorly understood in prisons. As self-reported by inmates in the Inmate Survey (1995) high risk behaviours such as injection drug use, sexual activity, tattooing and piercing do occur in prisons, often without the necessary precautions being taken to prevent the transmission of disease.

The Expert Committee on AIDS in Prisons, established by the Solicitor General in June 1992, examined the issues relating to HIV/AIDS in prisons. The final report of the Expert Committee, entitled *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS in Prisons*, 1994 (ECAP Report) took a strong public health approach to the problem of HIV infection and prisons and a harm reduction approach to drug use. The ECAP Report identified fourteen major issues raised by HIV/AIDS and drug use in federal institutions and made a series of recommendations with respect to the health of inmates and staff, and the prevention of the transmission of HIV and other infectious diseases in federal correctional facilities. Under NAS-II, CSC committed to carrying out many of the ECAP recommendations. By doing so, the Service supports two of the three main goals of NAS-II: stopping the spread of HIV/AIDS and the development of appropriate and effective ways to provide care, treatment and support to people living with HIV/AIDS, their caregivers, families and friends..

The mid-term review of NAS-II (1996), found systemic, organizational issues that impeded CSC's ability to effectively implement the initiatives of the National AIDS Program. They included a lack of structures, mechanisms and processes to implement the program; the absence of a meaningful data base to evaluate the program; little commitment and buy-in to the ECAP recommendations by CSC management and staff, and the limited authority held by the AIDS Coordinator to oversee implementation. Furthermore, the National AIDS Program was being implemented in a period of significant budgetary reduction and re-engineering within the Service with concomitant reductions of staff at the National and Regional Headquarters levels as well as changes to structures and working relationships. These issues all contributed to a slow-down in CSC's implementation of its National AIDS Program.

More recently, in September 1996, CSC received the report -HIV*/AIDS in Prisons: Final Report* , 1996 (Jurgens Report). This Report assessed CSC's progress in responding to the ECAP Report's recommendations and identified new developments that had arisen since the release of the ECAP report. The Jurgens Report assesses the federal and provincial correctional systems as being slow in implementing many of the ECAP recommendations, and for their failure or refusal to implement others.

This evaluation meets the requirement that a final evaluation report on the National AIDS Strategy - Phase II be submitted to Treasury Board by September 1997. CSC has conducted a parallel evaluation of CSC's participation in NAS-II. The CSC parallel study addresses the three main Treasury Board evaluation questions:

- relevance and continued need
- objectives achievement
- cost-effectiveness and alternatives.

The methodology for the CSC internal review included:

- a project file and document review,
- telephone interviews with Health Services staff in the regions responsible for implementing HIV/AIDS related activities and with Regional Coordinators Safety and Health, and,
- in-person interviews with National Headquarters Health Services management staff, the National HIV/AIDS Coordinator, and other National Headquarters staff with responsibility to implement aspects of CSC's National AIDS Program;
- a questionnaire to institutional Health Services Managers to assess the impacts of the initiative at the institutional level; and,
- a review of the responses to the National Inmate Survey, conducted in 1995.

A summary of HIV/AIDS related policies and practices of international jurisdictions is available under separate cover.

The timing of the final evaluation creates several limitations. The evaluation is being conducted approximately one year before NAS-II sunsets, and one year after the mid-term review. CSC has just begun to address the concerns raised by the mid-term review, as well as in the Jurgens Report, consequently, many of the initiatives are not sufficiently advanced to enable a report on their effectiveness and objectives achievement. As a result, the parallel evaluation reports primarily on progress toward achieving the objectives of NAS-II.

CSC's activities in support of the goals of NAS-II have focused on policy development, program delivery and evaluation, and issue management. Under these broad headings the Service is engaged in a range of activities. These include education for both staff and inmates; prevention; treatment and care; research; policy; and monitoring cases of HIV/AIDS. A large portion of the funds provided to CSC under NAS-II is dedicated to program development, particularly in the areas of harm reduction and education of inmates. A number of initiatives were undertaken on a pilot project basis before proceeding with national implementation.

Accountability for managing and coordinating CSC's activities resides with the Director General, Health Services and the National HIV/AIDS Coordinator.

Policy Development:
In the area of policy development, CSC has revised two Commissioner's Directives to respond to ECAP recommendations; Commissioner's Directive 821- Management of Inmates with HIV, and Commissioner's Directive 803 - Consent to Health Care Assessment, Treatment and Release of Information. In addition, national guidelines for

bleach distribution were prepared by a national working group to provide direction to operational units and to contribute to the consistent implementation of bleach distribution.

Program Delivery and Evaluation:
Under NAS-II funding support, program development activities have focused on:

- the introduction of harm reduction measures, specifically the distribution of bleach. Bleach was initially distributed on a pilot basis at Matsqui Institution, and based on the positive results of the pilot, CSC proceeded to national implementation;
- the development of health promotion, and HIV/AIDS education resources to assist health services staff in the delivery of HIV/AIDS education and training to inmates. A peer education program for inmates has been developed on a pilot basis at Dorchester Institution, and is currently being assessed as a model for national implementation;
- developing a better understanding of HIV/AIDS in prisons through general research initiatives. This has included incorporating into the Inmate Survey (1995) questions regarding high risk behaviours in its penitentiaries, a review of HIV/AIDS injection drug use and harm reduction practices internationally, and a review of legal and ethical issues by the Canadian HIV/AIDS Legal Network and Canadian AIDS Society (Jurgens Report);
- the inclusion of research designs in developmental initiatives such as the Matsqui bleach distribution and Dorchester peer education pilots.

Issue Management:
In the area of issue management, the Service has worked in partnership with external organizations and other levels of government to develop several of its initiatives under NAS-II. The most significant are:

- the Matsqui Bleach distribution pilot had input from both AIDS Vancouver and The British Columbia Centre for Excellence in HIV/AIDS;
- the Dorchester Peer Education pilot was developed with AIDS New Brunswick;
- the development of health promotion materials was a joint initiative between CSC and the province of British Columbia;
- recently a Federal/Provincial/Territorial working group to the Heads of Corrections has been established to address interjurisdictional policy issues; and,
- CSC has contributed funding and other support to the Prisoners with HIV/AIDS Action Network for the first national HIV/AIDS in Prisons Workshop.

While there has been considerable external involvement in major developmental initiatives, there is considerably less involvement of community based AIDS organizations, or health and social service agencies at the operational level.

ASSESSMENT OF CSC'S PARTICIPATION IN NAS-II

Relevance and Continued Need:

As an operational agency, responsible for the delivery of health services to federal inmates, CSC's activities under NAS-II are consistent with the NAS-II's overall objectives and with CSC's legislative mandate, its Mission and Health Services Standards.

The funding support provided by NAS-II enabled CSC to conduct several developmental activities to respond to HIV/AIDS. CSC has made some positive progress toward addressing the recommendations contained in the ECAP Report. However, more work remains to be done, particularly in the area of program delivery and research. A number of gaps have been identified with respect to the delivery of a comprehensive AIDS program in CSC.

The following represent the major work yet to be initiated or completed:

- While prevention education is provided to new recruits during their orientation, and to inmates upon reception, CSC needs to be more proactive in ensuring a consistent standard of delivery of refresher prevention education and training to both staff or inmates, and in providing its professional staff with the necessary education to enable them to effectively care, treat, and support HIV infected inmates. This was identified by the majority of staff as a major weakness of CSC's National AIDS Program. The needs of inmates will be addressed, in part, with national implementation of the Dorchester peer education model.

- Further assessment is required of the feasibility of introducing further harm reduction measures in federal institutions, including needle exchange, permitting tattoo and piercing services to be delivered by qualified inmates inside the penitentiaries, and methadone therapy, including maintenance.

- CSC has yet to complete work it initiated regarding issues respecting anonymous testing and related issues of protecting confidentiality in a correctional environment.

- To obtain a better understanding of HIV/AIDS in its institutions, CSC intends to conduct, in collaboration with Health Canada, a study of seroprevalence rates in federal institutions; and,

- The needs of women and Aboriginal offenders have yet to be assessed.

The scope of the work that remains to be completed will require CSC to undertake activities beyond the period of NAS-II. Funding through a renewed initiative or through internal reallocations would not only continue CSC's work in this area, but also extend support for established services and allow for the expansion of these services.

Staff expressed concern that many of these activities will not be sustainable in the absence of a federal role and funding support.

Within CSC there was general support for expanding the scope of the National AIDS Strategy to address all infectious diseases, particularly blood-borne pathogens. There was a concern expressed that the attention focused on HIV/AIDS had detracted from a focus of the issue of infectious diseases generally. Many of the education and prevention requirements are not unique to HIV/AIDS.

The view was also expressed that accountability for administration of the program should shift from Health Services to Correctional Programs. It was felt that this organizational shift would give HIV/AIDS a greater prominence and a greater likelihood of acceptance as a corporate priority.

Implementation and Objectives Achievement:

CSC's contribution to the achievement of the goals of NAS-II is contingent on implementing the ECAP recommendations and addressing the concerns raised in both the mid-term evaluation, as well as the more recent Jurgens Report. The most significant is the need to be proactive in developing a comprehensive program strategy, and an effective infrastructure and partnership approach to administer the initiative at all levels of the organization. CSC's response to HIV/AIDS has been characterized as being reactive.

Several additional issues emerged with respect to administration of CSC's National AIDS Program which significantly impacted on CSC's ability to achieve its objectives under NAS-II. They include:

- inadequate analysis of the impact of the organization's receptivity to the ECAP recommendations, and the impacts and impediments to implementation at the operational level;

- weak internal partnerships, particularly in involving all sectors and levels of the organization in strategic planning and defining priority areas of action. This may have contributed to weak "buy-in" from management and staff;

- weak coordination, collaboration and information-sharing mechanisms to facilitate information-sharing between all levels of the organization, and particularly with the institutions. Operational staff reported that they did not always have sufficient direction with respect to implementation of key initiatives. This contributed to inconsistent implementation nationally.

- absence of clear accountability for administration of the program as a whole particularly at the regional and operational levels, and for monitoring and reporting on progress on specific initiatives. Accountability was assigned on an initiative specific basis, such as in the bleach kit distribution, as opposed to implementing the AIDS program;

As a result of these weaknesses relating to the administration of the program, CSC's response to HIV/AIDS emerged as a series of stand-alone initiatives, as opposed to a comprehensive program response.

This evaluation has highlighted a number of areas requiring greater attention by CSC if it is to positively contribute to the achievement of NAS-II objectives. They include:

- greater administrative and professional support to health services staff from their NHQ and RHQ counterparts;
- a stronger leadership role on the part of NHQ in establishing program standards to ensure national consistency in the implementation of various key initiatives (e.g. inmate and staff education, condom distribution);
- related to the previous point, a strong role for NHQ in ensuring a nationally consistent standard for training of staff and inmates. This was identified as a major weakness in CSC's response to HIV/AIDS and one which, if not addressed, with adversely impact on CSC's ability to address the issues of HIV/AIDS.
- providing levels of resourcing and support equivalent to that provided to pilot institutions when implementing initiatives nationally.
- accountability at the regional and operational levels for implementation of the program;
- improving information collection on HIV/AIDS cases, risk behaviours, and the care, treatment and support provided, to support management and evaluation of the program;
- ensuring that evaluation frameworks are integral to developmental initiatives to enable the assessment of impacts of initiatives; and,
- a stronger compliance monitoring function by Health Services to ensure consistent implementation and corrective action when necessary.

CSC has just begun to make significant progress in addressing many of the issues raised in both the mid-term review and the Jurgens Reports. Most importantly, CSC is shifting from a "reactive" Health Services driven response to HIV/AIDS to one that has mobilized all sectors of CSC toward the development of an integrated, multi-disciplinary, multi-sectoral program initiative. Specifically,

- the development of an integrated, multi-disciplinary program framework, involving all Sectors of CSC, to address both ECAP/Jurgens recommendations and to establish a viable HIV/AIDS program;
- establishment of several committees, an Infectious Diseases Committee with regional members responsible for overseeing implementation of initiatives regionally, and to serve as a mechanism for coordination and collaboration on HIV/AIDS issues, an Implementation Committee, comprised of National and Regional staff to oversee the broad implementation of the National AIDS Program; a National Infectious Diseases Committee comprised of senior managers from the Service and from Health Canada, to advise Executive Committee on issues and actions required in response to infectious diseases;
- the identification of staff at the regional and operational levels with clearly defined accountability for implementing the National AIDS Program initiatives;
- the identification of deficiencies in CSC's response to HIV/AIDS and plans of action to address them.

CSC has made positive progress toward developing plans of action to address the identified deficiencies identified in the mid-term evaluation and Jurgens reports. However, as proposed activities are still in the planning stage, it is too early to assess if the proposed corrective action will impact on CSC's contribution toward meeting the objectives of NAS-II. This evaluation, therefore, reports on progress toward the achievement of the objectives.

Despite the weakness identified in CSC's implementation of HIV/AIDS initiatives, CSC has made progress toward the goals of NAS-II. Institutional staff report that the initiative gave HIV/AIDS in prisons a higher profile, increased knowledge about HIV/AIDS in prisons, and increased CSC's attention and staff awareness to HIV/AIDS. Staff also reported that NAS-II had enhanced CSC's capability to deliver programs and services.

The most substantive progress under the initiative was in the development of training resources for inmates, such as health promotion training materials and inmate peer education and prevention measures such as bleach kit distribution. These initiatives were all funded through NAS-II to respond to the needs of inmates with HIV/AIDS. CSC actively promoted partnerships with external expertise and community-based AIDS service organizations in the development of these initiatives. CSC also made substantial changes to its policy in direct response to the ECAP recommendations.

Special funding under the initiative have provided opportunities for CSC to explore new concepts and develop program models such as inmate peer education, and bleach kit distribution. For the most part it contributed to the introduction of programs which responded to the needs of inmates which were not necessarily being addressed within existing resources.

These programs were largely experimental in nature and were tested via pilots before a decision was taken regarding their viability for national implementation. CSC must be cautious in taking this approach, and ensure that developmental work is evaluated in terms of its effectiveness.

Cost-effectiveness and Alternatives:
NAS-II funding increased CSC's capacity to respond to HIV/AIDS by providing CSC the resources to focus explicitly on implementing some of the more complex components of the ECAP recommendations. In the absence of funding support, these components would have competed for resources with other Service priorities and would have developed more slowly, if at all.

Operational units were not provided resources to support the implementation and delivery of the newly developed programs or services and health care budgets were not increased to reflect new responsibilities associated with implementation of the HIV/AIDS initiatives. Inadequate person year resources was the most frequently cited impediment to effective implementation at the operational level. Should the National AIDS Strategy be renewed, operational units should be allocated the necessary resources to support implementation of new initiatives.

Expenditures associated with the developmental components of the program, however, are seen as extremely high, and CSC still has considerable work to do in this area (e.g. needle exchange, methadone maintenance, implementation of peer education). Continued NAS funding support is an effective way to ensure that CSC will be able to carry out future developmental activities.

Some staff perceived that the most effective means of addressing HIV/AIDS is to maintain a specific focus so that the efforts are sharply targeted and amenable to assessment in terms of their impact. Alternatively, other believe HIV/AIDS is one part of the broader problem of the transmission of blood-borne pathogens and believe that HIV/AIDS should be subsumed under a broader initiative relating to infectious diseases.

CSC is in the process of determining the cost requirements to continue with HIV/AIDS programming beyond 1997/98. Costs to implement the components of the program framework far exceed the resources that are forthcoming through NAS-II. Estimates for future funding will be incorporated into the National Capital, Accommodation and Operations Plan.

Summary and Conclusions:

Considerable further work remains to be completed. CSC has recognized this and is in the process of defining where it should focus its resources in the upcoming years. Resources will be required for further developmental work, particularly in the area of harm reduction, such as needle exchange, tattoo and piercing equipment in institutions, and methadone maintenance therapy. Work in these areas will likely be undertaken on a pilot basis. It is hoped that this developmental work will provide CSC with comprehensive models . More specifically, these pilots should provide CSC with materials and manuals describing the implementation of the program, and detailed reports on research findings and effectiveness of the programs. The initiatives can then be replicated in other sites. CSC should ensure that it measures and records the outcomes of the pilots.

Greater attention must be paid to the impediments to successful implementation of HIV/AIDS activities and initiatives at the local level, particularly the availability of resources, specifically person year, to effectively administer the program in the institutions. The opportunities provided by NAS-II to undertake developmental activities at the National Headquarters level must translate into action at the operational level if CSC is to impact on the objectives of NAS-II.

LIST OF RECOMMENDATIONS

RECOMMENDATION ONE:

That the Security Branch examine the patterns of drug use to assess the validity of the concern that inmates are shifting to injection drugs to avoid detection during random urinalysis.

RECOMMENDATION TWO:

Should Health Services receive funding from a renewed NAS, it should continue to encourage a internal partnership in the National AIDS Program. Health Services should consider establishing processes:

- to seek proposals for HIV/AIDS related activities from other sectors, regions and institutions (e.g. call letter to National Headquarters Management Committee, and Executive Committee), and
- to review, approve and resource them.

RECOMMENDATION THREE:

Health Services should share the Ontario experience with the other Regions.

Regions should examine the feasibility of a resource dedicated to addressing issues regarding infectious diseases.

RECOMMENDATION FOUR:

To improve information-sharing between all levels:

Health Services, National Headquarters, in consultation with the Regions, should clarify responsibility for information-sharing with institutional staff, and determine mechanisms to inform staff at all levels, and others, on a regular basis, of CSC activities in the area of HIV/AIDS e.g. Bulletins, regular meetings of coordinators; and,

That Health Services at National Headquarters table the information sharing issue as an agenda item at any future Health Care conference.

RECOMMENDATION FIVE:

That a role statement of the Regional and Institutional AIDS Coordinators be developed and that it include the requirement to actively promote community-based partnerships in the delivery of training and other services to inmates.

RECOMMENDATION SIX:

Health Services should carefully assess the transferability of pilot results to each operational unit before proceeding with national implementation.

RECOMMENDATION SEVEN:

With respect to inmate education:

That Health Services develop a nationally consistent standard for inmate education/refresher to define, more precisely, the term "periodically."

To ensure that the momentum created by the pilot at Dorchester Institution not be lost, that health services at National Headquarters move quickly to develop a minimum national standard for the delivery of peer education.

RECOMMENDATION EIGHT:

With respect to staff education:

That the Personnel and Training Sector give consideration to modifying the national course standard in relation to infectious diseases to make staff refresher education an essential requirement.

That accountability for the delivery of refresher staff education be clearly defined, and the most appropriate delivery mechanisms identified.

RECOMMENDATION NINE: With respect to professional development of Health Services employees:

That the Personnel and Training Sector, in consultation with Health Services, assess the professional development needs of Health Services staff; and

That, on the basis of the identified needs, Personnel and Training in collaboration with Health Services, determine appropriate delivery mechanisms for education/ training of health services professionals.

RECOMMENDATION TEN: In the event of a renewal of the NAS, that CSC negotiate its own allocation of resources under the initiative.

RECOMMENDATION ELEVEN: That Health Services initiate an assessment of the impact of the elements of the National AIDS Program on operational units, including an assessment of resources required to ensure full implementation and, if necessary, examine options to ensure implementation is resourced.

RECOMMENDATION TWELVE: That National Headquarters Health Services, in consultation with the Regions, identify the information critical to the on-going management and evaluation of CSC's National AIDS Program, its operations, services and costs, and develop the necessary information collection mechanisms, management controls and monitoring tools to collect this information.

RECOMMENDATION THIRTEEN:

That Health Services strengthen efforts to develop and implement research and evaluation frameworks for HIV/AIDS programs to ensure a consistent approach to program and project monitoring and reporting. This should include effectiveness evaluation and data on achievement of project/program objectives commensurate with the size and complexity of the individual projects/program.

1. INTRODUCTION

1.1 BACKGROUND - NATIONAL AIDS STRATEGY - PHASE II (NAS-II)

In the late 1980s, the federal government initiated a National AIDS Strategy to respond to the growing epidemic of HIV/AIDS in Canada. The then Department of National Health and Welfare coordinated efforts to mobilize all affected sectors, the objective being to develop an infrastructure of partnerships to develop an effective, collective response to HIV/AIDS in Canada.

In March 1993, Cabinet approved Phase II of the National AIDS Strategy (NAS-II) and in excess of $200 million to be spent over five years, beginning in April 1993 and ending March 1998, to build on Canada's initial response to the epidemic under . NAS-II continued to encourage more collaboration and to build closer links with the public and private sectors.

Funds were allocated to Branches in Health Canada, the lead department for the initiative, the Medical Research Council, and the Correctional Service of Canada (CSC). The Service is one of more than a dozen responsibility centres working collectively to respond to the achievement of shared goals. These goals are the same as in phase I of the NAS, and are outlined in Health Canada's Evaluation Framework dated June 1994. They are as follows:

1. **to stop the spread of HIV/AIDS** --giving people, particularly those with high risk behaviours, the information and social support they need to develop the skills to protect themselves.

2. **to develop more appropriate and effective ways to provide care, treatment and support to people living with HIV/AIDS, their caregivers, families and friends**– learning more about the needs and finding innovative ways to provide the care and support required.

3. **search for effective vaccines, drugs and therapies** -- contributing to worldwide efforts to either find a cure for AIDS or an effective way to stop the virus.

A fourth overriding goal was added:

> 4. **implement Phase II of the National AIDS Strategy effectively**–using all our skills, resources, and knowledge to further develop effective policies, programs and services.

NAS-II also emphasizes evaluating all programs and projects to ensure that each is achieving its goals and managing its resources effectively.

While the goals under NAS-II remained unchanged from Phase I, the approach for pursuing them did change to focus on the policy themes of enhancing partnerships, recognizing HIV disease as a chronic and progressive condition, promoting health for people living with HIV/AIDS, encouraging supportive social environments, and promoting and sustaining healthy behaviour. The federal government approved funding for five generic types of activities to support the goals of Phase II of the Strategy. These are:

- coordination and collaboration;
- education and prevention
- research and epidemiological monitoring;
- community development and support of non-governmental organizations; and
- care, treatment and support.

1.2 CSC'S PARTICIPATION IN NAS-II

In recent years, HIV infection has become a public health threat to the whole community. It is, however, much more common among those who engage in certain high-risk behaviours such as injection drug use and unprotected sex. One of the vulnerable populations is Canada's offender population. Issues raised by HIV/AIDS and drug use in prisons have been the subject of considerable concern and controversy. In an effort to resolve these issues, the Solicitor General established the Expert Committee on AIDS and Prisons (ECAP) in June 1992. ECAP's mandate was to recommend ways to prevent the transmission of HIV and other infectious diseases in federal penitentiaries and to promote and protect the health of inmates, staff and -- since most inmates are in prison for relatively short periods of time – the general public.

The *Final Report of the Expert Committee on AIDS and Prisons - HIV/AIDS in Prisons* (ECAP Report) was released by CSC in March 1994.[1] The final report took a strong public health approach to the problem of HIV infection in prison and a harm reduction approach to the problem of drug use. The authors recognized that several of the report's recommendations would appear to conflict with established correctional policy, however, contended that such measures may be necessary to protect inmates, staff and the public from the much greater harm of HIV infection. This concept of "lesser harm" is in keeping with the law, the principles of CSC's Mission Statement, and policy – that the goal of imprisonment is rehabilitation, not punishment, and that the same standards of health care and protection that apply to people in the general community should also apply to offenders.

The ECAP report identified 14 major issues raised by HIV/AIDS and drug use in federal institutions:

- seroprevalence studies;
- HIV testing;
- offender medical information;
- the housing and activities of inmates with HIV;
- educational programs for inmates;
- preventive measures for inmates;
- protective measures for staff;
- health care;
- tuberculosis;
- prison health services;
- compassionate release;
- aftercare;
- women inmates; and,
- Aboriginal inmates.

The ECAP report set the stage for CSC's response to HIV/AIDS. The Service accepted recommendations which focus on a number of initiatives in the areas of:

- education for both staff and inmates;
- prevention;
- treatment and care;
- research.
- policy
- monitoring cases of HIV/AIDS.

Under NAS-II CSC agreed to many of the recommendations contained in the ECAP Report. In the context of responding to the ECAP Report, CSC contributes to all goals of NAS-II, with one exception; the Service has no role in the search for effective vaccines, drugs and therapies.

The management of CSC's National AIDS Program is the responsibility of the Director General, Health Services and the National HIV/AIDS Coordinator. Health Services is accountable for the development, coordination and implementation of the initiative within CSC. In addition, the National HIV/AIDS Coordinator acts as a liaison point with the other components of NAS-II, in particular Health Canada, which is the lead department and responsible for the overall coordination and evaluation of the initiative.

1.3 EVALUATION OF NAS-II

Ultimate accountability for the initiative is with Treasury Board. As a condition of funding approval, the Treasury Board asked that the National AIDS Strategy be carefully monitored, both to evaluate its effectiveness and to identify any new or emerging issues that should be examined. Health Canada was asked to submit a final evaluation report by September 30, 1997, six months before the end of funding. In this regard, an evaluation framework[1] was completed in 1994 which identifies questions and indicators to assess the success and effectiveness of the strategy as a whole, as well as each of its responsibility centres.

A mid-term review was also completed in the Spring of 1996. The mid-term review examined whether all the elements necessary for the Strategy's success were in place, whether mid-term corrections were necessary, and whether the information needed to evaluate the Strategy's success was being collected.

As was the case with the mid-term review, the Performance Assurance Sector of the Service is responsible for undertaking a parallel review for the CSC component of the Final Evaluation of the National AIDS Strategy - Phase II.

1.4 SCOPE AND FOCUS OF THE STUDY

This report presents the findings of the final evaluation of the CSC component of the National AIDS Strategy - Phase II. The final evaluation of NAS-II focuses on the three main issues identified in the Treasury Board policy on evaluation and review:

- relevance and continued need;
- objectives achievement and success; and
- cost effectiveness of the activities and approaches taken by the Strategy.

The five generic activities undertaken by the NAS-II are assessed in terms of these broad issues.

---

[1] Health Canada. Evaluation Framework - National AIDS Strategy - Phase II. June 2, 1994.

As a major thrust of NAS-II is to strengthen partnerships, the evaluation also focuses on the success of the federal components in establishing and maintaining effective linkages with other parties (other countries and international agencies, provincial and territorial governments, AIDS-specific NGO partners, other non-governmental organizations, researchers, professional organizations, private sector and groups representing ethnic and cultural communities). Therefore each component includes questions to examine what structures and processes were established to share information, identify problems, establish priorities and agendas for cooperative action, allocate resources, and share the knowledge.

The generic evaluation questions that guided the CSC component of the evaluation are shown in Exhibit 1. In addition, and consistent with the approach taken by the Health Canada evaluation, questions were added focusing on incrementality, alternatives and on how well CSC has addressed the issues identified in the mid-term review, viewed as critical to the success of the initiative. CSC's mid-term review identified the following deficiencies:

- lack of structures, mechanisms and processes critical to the success of NAS-II;
- absence of a meaningful data base with which to gather the necessary information and statistics to evaluate the success of NAS-II;
- lack of commitment and buy-in in the implementation of the ECAP recommendations; and,
- lack of authority of the AIDS Coordinator to oversee the implementation of the ECAP recommendations.

The results and conclusions of CSC's parallel study will be incorporated into Health Canada's Final Evaluation Report on the National AIDS Strategy - Phase II. The final evaluation:

- reports on the performance and success of NAS-II and its impact on HIV/AIDS in Canada in relation to the three goals;
- examines the extent to which the federal programs and activities are still needed to respond to HIV/AIDS epidemics and assess whether there are unmet needs to which the federal government is best positioned to respond; and,
- reports on the responsiveness of the Strategy.

1.5 METHODOLOGY

The methodology for this study included: a file and document review, an assessment of coordination mechanisms, telephone interviews with regional and in-person interviews with National Headquarters staff, questionnaires to institutional Health Services managers to assess impacts of the initiative at the institutional level, a review of high risk behaviour of inmates as reported in the 1995 Inmate Survey and an international comparison of CSC's performance relative to other countries. This last piece will be a stand-alone document.

In total 17 interviews were conducted with CSC staff, including interviews with the following individuals:

- the National HIV/AIDS Coordinator;
- National Headquarters staff responsible for activities under the initiative(Personnel and Training, Aboriginal Programs, Health Services, Security)
- Health Services staff responsible for regional coordination of activities under the initiative; and
- Regional Coordinators, Occupational Safety and Health.

Forty-five questionnaires were distributed to all Health Care Centres, Mental Health Units, and Regional Psychiatric/Treatment Centres. Twenty-seven were returned, representing a response rate of 60%. The following is a breakdown of returns by Region.

Table 1 - Response to the Survey of Health Services Staff

Region	# Distributed	# Returned	%
Atlantic	6	5	83.3
Quebec	11	5	45.5
Ontario	12	6	50
Prairies	9	7	77.8
Pacific	7	4	57.1
Total	45	27	60

Exhibit 1 - Correctional Service of Canada - Generic Evaluation Questions[2]

RELEVANCE AND CONTINUED NEED

1.1 How comprehensive and appropriate are the activities of the National AIDS Program?
1.2 To what extent has CSC's capability to develop, implement and deliver services and programs been enhanced by the funding and support of NAS-II?
1.3 How sustainable are CSC activities should there be changes in the federal role and resources?

OBJECTIVES ACHIEVEMENT AND SUCCESS IN ACHIEVING THE GOALS OF NAS-II AND RESPONDING TO HIV/AIDS IN PRISONS

NAS II Goal: STOPPING THE SPREAD OF HIV

Activity: Epidemiological Monitoring
2.1 To what extent is the epidemiological database CSC maintains on HIV/AIDS incidence and prevalence useful for, and used to influence the design and delivery of programming for offenders?

Activity: Direct Service Delivery
2.2 To what extent have HIV/AIDS prevention/education services been made available to all CSC offenders and staff?
2.3 How successful have CSC education services and prevention measures for offenders been?
2.4 To what extent does the HIV/AIDS prevention/education training of staff respond to the needs and integrate with other health service training for staff?
2.5 Have CSC prevention/education activities resulted in improved services for offenders?
2.6 Have CSC research and evaluation activities enhanced the education/prevention and care, treatment, and support services to offenders in correctional settings?

---

[2] This chart is derived from the Evaluation Framework - National AIDS Strategy - Phase II, Annex B. 1994. Questions on incrementality, sustainability, cost-effective alternatives, and coordination and collaboration have been added to coincide with the Health Canada Evaluation. These are identified by the italics.

NAS II Goal: PROVIDING CARE TREATMENT AND SUPPORT

Activity: Direct Service Delivery

2.7 Is the training to CSC staff in care, treatment and support sufficient and effective?

2.8 Have CSC's training activities in care, treatment and support resulted in improved services to offenders?

2.9 How comparable are the care, treatment and support services provided by CSC to offenders to corresponding services in the community?

2.10 To what extent has CSC succeeded in increasing accessibility to post-release services for education and prevention, and care, treatment and support?

COST EFFECTIVENESS AND POSSIBLE ALTERNATIVES

3.1 How cost effective was the National AIDS Program?

3.2 Are there cost-effective alternatives for program delivery?

COORDINATION AND COLLABORATION

4.2 How appropriate are the mechanisms in place for coordination and collaboration (departmental, international, interdepartmental, with non-government service delivery agencies?

4.12 How effectively has CSC, National Headquarters monitored the implementation of the National AIDS Program?

4.3 How effectively has CSC National Headquarters facilitated the management of strategic issues?

Internal Review:

The internal review focused on addressing issues consistent with the key Treasury Board evaluation questions: relevance and continued need, objectives achievement and success, and cost-effectiveness and alternatives. In addition questions related to coordination, contribution of NAS-II funds to CSC's ability to undertake HIV/AIDS activities, and sustainability of activities if the federal role and funding ceased or were reduced. The review also followed-up on the observations of the mid-term review to assess whether issues related to the required corrections for the success of NAS-II had been addressed.

The review assessed the progress that has been made since the mid-term evaluation with respect to key commitments made by CSC in response to the ECAP report.

Structured interviews were conducted with managers and staff involved with planning, coordinating, funding and implementing the initiatives and activities of CSC's National AIDS Program. In-person interviews were conducted with National Headquarters managers and staff. Regional Health Services staff responsible for coordinating HIV/AIDS related activities within their regions were also interviewed. Regional Health Services staff were chosen for interviews because of their responsibility for implementing and/or coordinating key aspects of CSC's National AIDS Program (e.g. Bleach distribution) within their regions. Interviews with regional staff were conducted by telephone.

A qualitative analysis of interview data was undertaken and key themes that emerged from the participants' responses have been reported.

File and Document Review:
Correctional Services of Canada files, reports and documents dated from the onset of NAS-II (April 1993) to present were examined to obtain information on:

- annual financial and operational data such as annual budgets and resource allocations, particularly financial support to conduct activities in support of the program component;
- annual operational plans and priorities;
- statistical and epidemiological data
- project/activity files
- annual progress reports';
- records of meetings between Health Services and other CSC participants in the initiative;
- record of meetings between CSC Health Services and other participants in the NAS-II;

- progress reports on responses to the ECAP presented to Executive Committee and the Minister.
- status reports from regions on initiatives undertaken.
- evaluations of projects and services;
- distribution records (information dissemination)
- collection of information from other jurisdictions

The file reviews will augment information obtained through the other methods of inquiry as well as provide information on whether the Program was implemented as planned.

Questionnaire - Institutional Chiefs Health Services:

A questionnaire was distributed to all Health Care Centres, Mental Health Units, and Regional Psychiatric/Treatment Centres, to obtain nursing staff perceptions on the effectiveness of CSC's National AIDS Program generally, and more specifically on direct impacts on their institution. The following are the key lines of inquiry:

- effectiveness of internal coordination and collaboration and information sharing;
- whether the resources allocated to CSC under NAS II and the initiatives that resulted have influenced their ability to carry out HIV/AIDS related care, treatment and support and prevention activities (both in terms of delivery of services to offenders and their own knowledge and capacity to carry out activities);
- sustainability in the absence of continued funding support
- their perceptions of the effectiveness of the CSC activities carried out under NAS-II;
- impediments to effective implementation; and
- perceptions of where further action is required and continued need.

The Chiefs, Health Services were also asked to identify gaps and areas requiring improvements. They were notified of the survey by phone in advance of the survey being sent to them electronically. They were provided the option of returning the survey by facsimile or by Electronic mail.

National Inmate Survey:

The National Inmate Survey was completed in the fall of 1995, under contract with Price Waterhouse. It provided a profile of risk-related activities of the federal offender population and information on the impact of CSC's activities related to HIV/AIDS from the perspective of the federal offender population. ECAP provided significant impetus for conducting the survey. The results of the survey have significantly enhanced CSC's knowledge of HIV/AIDS in CSC institutions, specifically behaviours which place offenders at risk of infection.

Although the questions are not directed specifically to the National AIDS Strategy, the results provide some assessment of CSC's effectiveness in implementing harm reduction, education and prevention measures from the perspective of federal offenders. The results also provide information on issues of impact and continued relevance.

International Comparisons:

The review will rely on a report recently completed on behalf of CSC entitled *Final Report - HIV/AIDS in Prisons* prepared by the Canadian HIV/AIDS Legal Network. This Report provides an analysis of CSC performance relative to that of prison systems in industrialized countries.

1.6 LIMITATIONS OF THE EVALUATION

There are a number of limitations to the evaluation which must be noted. First, Treasury Board directed that the final evaluation of the interdepartmental initiative be completed by September 30, 1997. This required that the evaluation commence approximately one year before the end of the initiative and approximately one year after the mid-term review. This made it difficult to address alternatives and objectives achievement issues, mainly because CSC has just recently begun addressing a number of the issues raised in the mid-term review and projects are just being initiated. Consequently, some of the projects are not far enough advanced at this time to provide any effectiveness data. The evaluation of these activities therefore focuses on progress to date toward many of the objectives.

Second, the CSC parallel study was completed under tight time frames. The elapsed time to complete the CSC parallel study was 2-1/2 months (mid-March-May). These time frames were necessary to permit integration of CSC's findings into the Interdepartmental Final Evaluation report. The short time frame impacted on the identification of performance indicators, data sources and data collection methods for the evaluation. For instance, it would have been desirable to undertake interviews with inmates, or alternately conduct an inmate survey, preferably by external expertise. Although this work could have been carried out internally, inmates are less likely to disclose sensitive information to CSC staff and this would have compromised the results. However, the timelines for the evaluation were too short to enable CSC to contract the project.

Finally, CSC has not yet rectified the problems identified in the mid-term review respecting its information gathering/information management capacity and systems so limited data was available for the purposes of this evaluation.

Consequently the methodology used for the purposes of the CSC parallel study is largely qualitative.

One of the important elements of the Final Evaluation of NAS-II is to determine how successful components of NAS-II were in establishing effective partnerships and linkages with other parties as well as horizontal integration and coordinated decision-making. The CSC parallel study has focused predominately on how well CSC has established effective partnerships and linkages with non-governmental agencies. It is assumed that the Health Canada evaluation will examine issues of collaboration and coordination between the components of NAS-II.

2. CONTEXT FOR CSC PARTICIPATION IN NAS-II

This Chapter describes the context in which NAS-II was implemented by CSC. To fully appreciate the circumstances and environment under which CSC's National AIDS Program was implemented requires an understanding of the CSC's organization structure, generally, and, more specifically, the delivery of health services to federal inmates.

2.1 FEDERAL CORRECTIONS SYSTEM

Corrections in Canada is the shared responsibility of federal, provincial and territorial governments. The provinces and territories are responsible for offenders serving sentences of less than two years. At the federal level. the Correctional Service of Canada, is responsible for the administration of sentences of two years and more.

CSC manages:

- 43 institutions for men which are classified as maximum, medium and minimum security. Two of these facilities follow a philosophy of Aboriginal healing;
- 7 facilities for women;
- 17 Community Correctional Centres for offenders on conditional release;
- 69 parole offices, and 19 district offices responsible for supervising conditionally released offenders in the community;

In addition, CSC has contracts with over 150 Community Residential Centres operated by community-based, non-profit organizations, for parole supervision and various support, treatment and education programs. CSC also maintains Exchange of Service agreements with most provinces and territories for similar services.

There are approximately 25,000 [3]offenders under federal jurisdiction - 15,000 incarcerated and 10,000 on some form of conditional release. The profile of the federal inmate population indicates that:

- 327 incarcerated offenders are female (April 1997)
- approximately 14% (1996) of the federal inmate population are Aboriginal.

---

[3] Correctional Service of Canada 1997-98 Estimates, Part III. 54.

The following are some key characteristics of the Aboriginal inmate population:

- one in eight federal inmates is Aboriginal, only one in 300 persons in the Canadian population is Aboriginal;
- three of four Aboriginal offenders have alcohol problems requiring treatment compared with one of the two non-Aboriginals;

The sentence lengths of the incarcerated federal population[4] are depicted in the following table.

Table 2 - Sentence Lengths of the Inmate Population

Term	Incarcerated %
under 2 years	0
2 to 3 years	17
4 to 5 years	14
5 to 6 years	11
6 to 7 years	9
8 to 9 years	6
9 to 10 years	5
Over 10 years	4
Life	6

Sixty percent of the inmate population is under the age of 40, 33% percent under the age of 30. The age breakdown of the inmate population is illustrated below.

Table 3 - Age Breakdown of the Inmate Population

Incarcerated	First Time%	Recidivist %	Total %
under 18	0	0	0
18-29	41	23	33
30-39	31	45	37
40-49	16	23	19
50-59	8	7	7
60-69	3	1	2
70-79	1	0	1
80+	0	0	0

---

[4] The totals include offenders under suspension and temporarily detained.

There is considerable movement of offenders in and out of custody. In fiscal year 1996/97, for example, there were 8,188 admissions and 8,043 releases from federal custody.[5]
CSC employs approximately 11,000 people. In addition, approximately 10,000 volunteers are involved in CSC activities.

2.2 HEALTH SERVICES IN THE CORRECTIONAL SERVICE OF CANADA

In Canada, provinces and territories are responsible for delivering most health and social services. However, federal inmates are excluded from provincial health plans under the *Canada Health Act*. The *Corrections and Conditional Release Act* and *Corrections and Conditional Release Regulations* provide the statutory framework for the delivery of health services to inmates under CSC's jurisdiction. The CCRA and CCRRs, Commissioner's Directives, the Health Services Manual (1996) and Standards for Health Services (1995) delineate CSC's responsibilities with respect to the provision of health care to inmates nationally. The federal government is, therefore, responsible for the delivery of the full range of medical, dental and nursing, pharmaceutical , psychiatric and psychological services to inmates while they are incarcerated in federal correctional facilities. Serious medical problems or special requirements that cannot be met internally are referred to health care facilities in the community. In addition, the Service provides conditionally released offenders with psychiatric, psychological and other rehabilitative services not provided through the provincial health care plans.

The following Health Services policy statement articulates CSC's philosophy respecting inmate health care:

> ***We recognize and support that primary responsibility for the health status of inmates rests with individual inmates and that CSC will work with them in the management of health related issues.***[6]

Although offenders have primary responsibility for their own health and well-being, the objectives of Health Services state that CSC is responsible for ensuring "appropriate, equitable and adequate access" to professional physical and mental health services. These services sustain and enhance health status, contribute to the inmate's adjustment within the institution and assist them in becoming law-abiding citizens.

---

[5] Offender Management System, CSC, May 1997.

[6] Correctional Service of Canada. Health Services Manual. Ottawa: CSC, Health Services Branch, April 1996.

As a Branch, Health Services has adopted a proactive and holistic philosophy to offender health care. The prime focus has been identified as health promotion and disease prevention.[7]

2.3 CSC AND HEALTH SERVICES ORGANIZATIONAL STRUCTURE

CSC has three levels of management: national, regional and institutional. The National Headquarters (NHQ) provides support to the Commissioner and Executive Committee, and delivers corporate services to all of CSC. As well, NHQ is involved in program development and research.

Following a period of downsizing and devolution of responsibilities to the regions, CSC has recently begun to realign its organizational functions and associated responsibilities to strengthen the role of NHQ.

The Director General, Health Services does not have functional authority over regional and/or local health care staff, nor is he a member of Executive Committee or the National Headquarters Management Committee. The Director General provides subject matter expertise and advice to the Commissioner and Executive Committee. He reports directly to the Senior Deputy Commissioner who is responsible for the overall operations of the Service.

Regional Headquarters (RHQs) provide support to the Regional Deputy Commissioners and Regional Management Committee in implementing national policies and programs, developing regional policies, plans and programs. Each Region has a designated individual responsible for Health Services. Regionally there is considerable variation as to who is responsible for administering the Health Services budget and resources.

The institutions and district parole offices are responsible for the delivery of programs, secure housing and reintegration of offenders by implementing both national and regional policies and programs. All federal correctional institutions offer primary health care to inmates. Health Care Centres in medium and maximum level institutions provide ambulatory care clinics, in-patient accommodation and, in most cases, 24 hour nursing service. With the exception of Ontario Region, which operates Health Care Centres in minimum level institutions, all other minimums are served by Health Care Centres in nearby institutions.

---

[7] Correctional Service of Canada. Health Care Services Manual. Ottawa: CSC, Health Services Branch,
Chapter IV.

2.4 INCIDENCE OF HIV INFECTION IN CSC INSTITUTIONS

HIV prevalence in penitentiaries exceeds that of the general population in most western countries. This has been attributed to the concentration of risk groups and/or transmission of HIV within a prison setting. The true extent of HIV infection in Canadian prisons is largely unknown. Information on the number of HIV-infected Canadian inmates comes from two sources: reported cases of HIV/AIDS and seroprevalence studies.
As of March 31, 1997, there were 146 known cases of HIV/AIDS (132 HIV and 14 AIDS) in CSC institutions. This is the first year of a decrease, after a continuous increase across all five regions since CSC first started collecting statistics in 1989. For instance there were a total of 13, 27, 37, 49, 92, 109,138 and 159 reported cases of HIV/AIDS in federal penitentiaries for the month of April from 1989-1995 respectively.[8] This represents the number of reported current cases per region at the end of each month. It is important to underline that this does not represent the prevalence rate of HIV/AIDS in federal institutions. One must be cautious in attributing any changes in the number of known cases to increased/decreased rates of infection in the inmate population. These incidence rates may reflect the level of awareness and availability of testing, and the number of inmates coming forward to be tested.

Five seroprevalence studies have been conducted in Canadian prisons with rates ranging from 1%[9] in the only study in a federal institution to 7% in a medium provincial prison for women inmates[10] The federal study suggests a rate that is approximately 10 times higher than the rate in the Canadian population. A history of injection drug use was found to be strongly correlated with HIV-infection by the studies which gathered data on risk behaviours.

The full extent of infection with HIV and other infectious diseases in the penitentiary population is not known because testing remains voluntary, and in the case of HIV, the continuing stigma attached to the disease, both within and outside the penitentiary environment, often militates against offenders coming forward for testing. Moreover, CSC does not know how much HIV transmission is now occurring in institutions due to needle-sharing, tattooing and unprotected sex.

---

[8] Correctional Services of Canada, , Monthly reported cases of HIV/AIDS in Federal Penitentiaries. Ottawa: CSC, Health Services Branch, March, 1997

[9] Ford, P.M. , Alifo, A., Connop, M. D., et al. Seroprevalence of HIV-1 in a male medium security penitentiary - Ontario. Canada Communicable Disease Report, 20(6): 45-47.

[10] Hankins, C, Gendron, S, Handley, M, Rouah, F, O'Shaughnessy, M. HIV-1 infection in a medium security prison for women - Quebec, CDWR, 1989 15: 168-170.

2.5 RISK BEHAVIOUR FOR HIV TRANSMISSION IN PRISONS

In-prison transmission of HIV is poorly understood, although inmates do engage in a number of high-risk behaviours including consensual and non-consensual sexual activity, tattooing and piercing, and intravenous drug use, often without taking appropriate and effective protective measures to prevent transmission.[11]

Injection Drug Use:

A history of injection drug use is significantly associated with HIV seroprevalence among offenders. A large number of the offenders that enter into CSC institutions have long histories of substance abuse (over 50% being under the influence of some drug at the time that they committed their first offence). Based on data collected on admission, approximately 70% of all federal offenders present with substance abuse problems of sufficient severity to warrant formal treatment intervention. Examined in terms of severity, approximately 30% of offenders have low severity problems, 17% exhibit intermediate severity problems, 13% have substantial problems and 10% experience severe substance abuse problems.[12]

There is considerable evidence that drugs continue to enter and are used in federal institutions despite efforts by CSC to prevent and prohibit illicit drug use. A significant percentage of inmates with a history of injection drug use will engage in this behaviour while incarcerated, while other inmates inject drugs for the first time in prison. Many of those that inject drugs in prison report sharing their equipment without taking adequate measures to ensure that the equipment is clean.

The Inmate Survey (1995) confirmed that a high proportion of inmates engage in high risk behaviour. overall, 26% of respondents reported engaging in risky practices such as needle sharing, tattooing, or unprotected sex. In the case of drug use, thirty-eight percent of inmates reported having used at least one illegal drug since admission to their current institution, and 11% reported injecting an illegal drug since admission to their current institution. There was considerable variation among the Regions with Pacific (23%) reporting a higher than average percentage who had injected drugs. Drug use also increased with the level of security (3%, 12%, and 13% in minimum, medium and maximum security institutions respectively). Of those who reported having injected, 57% thought that the equipment was clean, 17% thought it was not and 27% did not know. That is, less than two thirds of the sample believed the equipment they had used had been clean. Quebec Region reported the highest percentage who thought that the equipment was not clean (26%) and Pacific had the highest percentage who thought that the equipment used to inject was clean (65%).[13]

---

[11] Correctional Service of Canada. National Inmate Survey. 1995.

[12] Correctional Service of Canada Research Report. The Offender Substance Abuse Pre-Release Program: Analysis if Intermediate and Post-Release Outcomes. August 1995.

CSC has undertaken a number of actions to combat drugs in federal penitentiaries. As one component of the National Drug Strategy, there has been an increased use of random urinalysis to test for drug use. Concerns have been raised, based on anecdotal comments from inmates, that the result of the increased use of random urinalysis, inmates are shifting from drugs that are detectable in the urine for lengthy periods of time (e.g. marijuana) to drugs that have much shorter windows of detection (e.g. LSD, cocaine, heroin, PCP). As a result there may be an increase in injection drug use. This is an issue that should be examined more closely by the Security Branch.

RECOMMENDATION ONE:

That the Security Branch examine the patterns of drug use to address the validity of the concern that inmates are shifting to injection drugs to avoid detection in urine.

Consensual and Non-Consensual Sexual Behaviour:

Responses to the Inmate Survey also provided information on sexual activity during incarceration. Six percent reported that they had had sex with another inmate since admission to the current institution. The results of this survey also point to the prevalence of unsafe sexual activity in that only 33% of respondents reported using condoms, while more than two thirds, 68%, reported having sex without protection.

Condoms have been available in federal institutions since January 1992.

Another risk factor for transmission of HIV/AIDS is through non-Consensual sexual activity. The Inmate Survey found the proportion of inmates who reported having been sexually assaulted by another inmate to be at a national average of 3%.

Tattooing and Piercing:

Another potential transmission route for HIV/AIDS is through the practice of tattooing and piercing. In fact, 45% and 17% of respondents to the National Inmate Survey had engaged in tattooing or piercing respectively while in prison.

---

[13] Correctional Service of Canada. 1995 National Inmate Survey: Final Report - Main Appendix. 1996

Seventy-two percent reporting that they thought the equipment was clean, with 8% thinking the equipment was not clean and 20% who did not know.

Table 1 summarizes the extent to which CSC inmates engage in high risk behaviour as reported by the National Inmate Survey, conducted in the fall of 1995.

The prevalence of blood-borne infectious diseases and dangerous practices within a penitentiary setting has been highlighted by two recent incidents. The threat of HIV transmission was judged to be particularly high in one institution after the discovery that an inmate diagnosed with AIDS had engaged in high risk behaviour. The inmate disclosed that he had shared needles, identifying 20 contacts. Following an education and awareness campaign by staff and the inmate committee, an additional 80 inmates came forward for testing, as possible contacts. In the second incident, an offender, known to be positive for HIV and Hepatitis C was discovered to be sharing a needle. Twenty more inmates came forward for testing. Test results indicate a number have tested positive for HIV and a larger number for Hepatitis C.

These results are likely to be representative as these episodes could occur in any location. This underscores the general lack of knowledge about epidemiology of infectious diseases in prisons.

Table 4 - Inmate Self-reported Risk Behaviours

High Risk Behaviours	% of sample	n	Total Responding	%/(n) of sample not responding
injection of illegal drugs	10.8%	391	3626	15.4%(659)
Injection with unclean equipment	1.8	66	3616	15.6
sex with another inmate	5.8	208	3616	15.6
unprotected sex with another inmate	4.1	146	3858	10.0
sexually assaulted	2.6	99	3834	10.5
pressured for sex by other inmates	6.2	236	3624	15.4
received a tattoo	44.5	1613	3624	15.4
received a tattoo using unclean equipment	3.8	139	3492	15.4
body piercing	17.0	593	3492	10.5
body piercing using unclean equipment	2.5	86	3492	18.5

2.6 ENVIRONMENT FOR IMPLEMENTATION OF NAS-II IN CSC

CSC Reorganization

CSC's National AIDS Program under NAS -II was implemented during a period of restructuring within CSC and significant budgetary cutbacks as part of the general austerity program at the federal level.

The major restructuring of CSC announced in 1994, in conjunction with an operational review and streamlining exercise, examined CSC's management, administration and operations components and practices with a view to significantly reduce expenditures. This exercise resulted in a restructured and reduced National and Regional Headquarters with concurrent adjustments to standards, policies and processes to streamline operations. It also created the role of Corporate Advisors to provide subject matter expertise and advice to the Commissioner and Executive Committee in certain key areas.

In line with the role of other Corporate Advisors, the Corporate Advisor, Health Services provided advice to the Commissioner and Executive Committee. While a member of National Headquarters Management Committee, the Corporate Advisor was not a member of Executive Committee and had no functional authority over regional and/or local health care staff.

As part of this restructuring, Health Services was required to find savings of six million dollars over a five year period as part of the overall resource reduction exercise.

In line with the changes occurring in the general public, with hospitals reducing and changing the mix of staff, cutting services and clustering administrative and other services, CSC Health Services reviewed its own practices, staffing levels, and Health Standards, and re-engineered medical services to more closely reflect the community models.

In the process of identifying significant cost savings, CSC's Executive Committee was compelled to create a new balance in the equation between level of service and money expended with respect to "Health Care" as a program in CSC. A new model of health care delivery was developed which reflects community standards and which is based upon inmates' "needs" rather than their "wants". This was accompanied with a shift to a health promotion/prevention model. Given that most staff had not been trained in the primary health model, it was identified as critical that orientation and re-education programs be developed for health services staff, so that they have the tools/additional skills to move toward the health promotion model. As well, the requirement for detailed professional education in this model to re-orient the practice of nursing professionals was identified. It was noted that "failure to be attentive to this detail runs the risk of undermining the entire process and its attendant savings." The extent to which these orientation and re-education programs were carried out has varied among the Regions.

More recently, the Service has moved to strengthening its National Headquarters' organization. It is too soon to tell how this will impact on Health Services or the National AIDS Program.

Management of the Initiative:

CSC's National AIDS Program (implementation of the recommendations of the Expert Committee on AIDS and Prisons (ECAP)) falls within the Health Services Sector.

Concurrent with broader organizational changes, there has been turnover of staff in the National AIDS Program itself that has also had a direct impact on CSC's ability to meet its objectives with respect to commitments made to ECAP. Over the period of NAS-II, three different persons have filled the role of National HIV/AIDS Coordinator. The previous two incumbents were project officers on secondment from Health Canada. After a six month period in which the position was vacant, the present incumbent was hired as a CSC employee. Inevitably, each time there is a change in staff, there is a loss of corporate memory, as well as a period of time required for adjustment and a learning curve for the new incumbent.

3. CSC ACTIVITIES UNDER NAS-II

CSC received $400,000 annually under NAS-II. This amount was subsequently reduced to $300,000 in 1996/97. CSC's National AIDS Program is managed by the Health Services Branch, under the direction of the National HIV/AIDS Coordinator. The Director General, Health Services and the National HIV/AIDS Coordinator have overall responsibility to develop CSC policy and standards with respect to offenders and HIV/AIDS, to coordinate the Service's activities, and to monitor and oversee the implementation of the National AIDS Program.

3.1 OBJECTIVES

The broad goal of the National AIDS Program of the Correctional Service of Canada (CSC) at the onset of the National AIDS Strategy - Phase II was articulated as follows:

> *"To contribute to the attainment of federal goals under the National AIDS Strategy, Phase II, by developing and implementing HIV/AIDS programs, policies and services within federal correctional facilities which respond in a comprehensive ways to the needs of federal inmates and staff, and contribute to the overall Canadian public health effort to stop the epidemic."*[14]

To achieve its mandate under NAS-II, CSC's implementation plan has focused on three broad areas under which the accepted ECAP recommendations fall: Policy Development, Program Delivery and Evaluation, and Issue Management. Exhibit 1 on the next page summarizes CSC commitments in response to the ECAP Report. These commitments define CSC's activities in response to HIV/AIDS during NAS-II.

3.2 ACTIVITIES AND OUTPUTS

The major activities fall under the broad areas of prevention, care, treatment and support, education and training of staff and inmates, research and evaluation, policy development and coordination and collaboration.

---

[14] Briefing Note. Correctional Service of Canada, National AIDS Strategy Phase II,: Five Year Objectives. October 1993.

CSC committed to carrying out the overall activities and outputs are illustrated in Exhibit 2. The contents have been derived from the evaluation framework and are the primary elements against which CSC is being evaluated.

The majority of funds provided to CSC under NAS-II are dedicated to the national agenda of program development, particularly in the areas of prevention and inmate training. To support and complement this national agenda, and to ensure the feasibility of the model and that implementation problems were identified and addressed, CSC undertook several of its initiatives on a pilot basis.

The following paragraphs will describe in more detail CSC's activities under the initiative , under CSC's three broad areas of activities of NAS-II: Policy Development, Program Delivery and Evaluation, and Issue Management. It should be noted that this is a representative list of activities.

Exhibit 1 - CSC Commitments in Response to ECAP

What CSC committed to in response to ECAP

CSC's response to the ECAP report was multi-faceted. CSC agreed to:

- strengthen policy in areas where recommendations were essentially consistent with existing policy and practice;
- pursue pilot projects in some of the more controversial areas such as bleach distribution. In its response to ECAP, CSC did not agree to a pilot needle exchange or methadone maintenance treatment, committing instead to vigorously pursuing current policies on interdiction of drugs, urinalysis testing and the treatment and rehabilitation of inmates with substance abuse problems;
- build on and improve educational programs for inmates about HIV/AIDS and drug use; including a pilot program to train and pay inmates as peer health counselors;
- more vigorously promote voluntary testing at reception and during incarceration, and to pilot test an anonymous HIV testing program in at least one institution;
- in the area of preventive measures and consensual sexual activity, to strengthen the existing policy of making condoms, dental dams and water-based lubricants easily and discretely available. However, due to legal and security implications, CSC did not accept the proposal to remove consensual sexual activity from category of institutional offences. CSC agreed to continue to make the prevention of sexual assault a priority and to make single-cell accommodation a long-term priority;
- allow inmates to engage tattoo and piercing services at their own expense but will continue to prohibit inmates from providing the service themselves or from possessing the equipment;
- with respect to protective measures for staff, to build on and improve current HIV/AIDS education programs during orientation regularly thereafter, to continue to provide staff with the protective clothing and equipment and procedural training to enable them to protect themselves from all infectious diseases, and to work closely with Health Canada to provide thorough follow-up of all staff exposed to the blood or blood-contaminated body fluids of any inmate or staff.
- amend Commissioner's Directive to more explicitly affirm the current policy and practices of housing inmates with HIV in the general population and of not limiting their activities except for medical and security reasons;
- continue to provide health care comparable to the community;
- aggressively monitor tuberculosis in its institutions and regularly review tuberculosis policies
- recommend inmates with progressive life-threatening diseases, including AIDS for compassionate release if they do not pose a public safety concern;
- provide continuity of care upon release; and,
- design education and prevention programs to meet the needs of women and Aboriginal inmates.

CSC did not accept recommendations to

- remove prohibition against consensual sex, due to the concern over the significant legal and security implications;
- to provide methadone maintenance therapy, noting that there was no medical indication to do so in the federal correctional facilities, and at the time there were relatively few maintenance programs in the community; and
- to do a pilot needle exchange as this poses serious legal and security problems for institutions and that internationally, there was no support from correctional authorities.

Consistent with findings of the ECAP report, the seroprevalence studies were not considered a priority since, although useful, they tend to be expensive research projects that are unnecessary for the implementation of prevention efforts.

Exhibit 2 Summary of CSC's Primary Activities, Products and Intended Impacts[15]

Activity	Products or Services	Intended Impacts
Goal #1: STOP THE SPREAD OF HIV		
1. Epidemiological Monitoring	Current, reliable and confidential data base on incidence, and prevalence of HIV/AIDS in CSC facilities	Epidemiological information used to influence design and delivery of CSC HIV/AIDS programming for offenders.
2. Direct Service Delivery	HIV/AIDS prevention/education services provided to offenders of federal correctional facilities. Staff trained to provide services. Policy and program responses to recommendations of the Expert Committee on AIDS and Prisons	Prevention education available to all CSC offenders and staff, quality comparable to that in general community, increased effectiveness of HIV/AIDS programming for offenders and staff.
Goal #2: PROVIDE CARE TREATMENT AND SUPPORT		
3. Direct Service Delivery	Care, treatment and support services to HIV+ offenders during incarceration and planning for post-release services. Trained CSC staff; training in HIV/AIDS integrated with other health training. Cooperation between CSC and community about care, treatment and support of HIV offenders. Policy and program responses to the recommendations of the Expert Committee on AIDS and Prisons.	Service providers appropriately trained for HIV/AIDS care, treatment and support. Improved capacity of the community to provide service. All HIV+ persons within CSC responsibility have ready access to confidential services comparable in quality to those available in the community. Improved service to offenders resulting from current knowledge of staff. Expertise brought to offenders and staff. Improved accessibility of services to HIV+ offenders post-release. Increased effectiveness of HIV/AIDS care and support for HIV+ offenders.

---

[15] This summary consolidates the CSC activities found in the Evaluation Framework - National AIDS Strategy - Phase II, June 1994.

Goal #4[16] - IMPLEMENT PHASE II OF NAS EFFECTIVELY[17]		
Facilitation of Information sharing and Collaboration	Coordination across branches within Health Canada and between other federal departments and agencies. Increased sharing of program plans and projects. Coordinated and collaborative approach to planning and communications with major partners: Branch AIDS Coordinators Meetings Branch Working Groups Interdepartmental Working Groups RDG meetings Quarterly National NGO Partner meeting Liaison with Branches, Departments and Agencies regarding policy and program development and implementation issues. Liaison with key F/P/T and NGO partners for example CAS, CHS, CPHA, CAHR, and CANFAR Communications with stakeholders regarding NAS-Phase II Recognizing the distinct mandates and expertise of all.	HIV/AIDS partners, to act together towards achieving the goals of NAS-Phase II. All available sources of expertise brought to bear on HIV/AIDS related issues in a complementary way. Clearly explained NAS Phase II goals and policy themes. Recognized and effective communications with stakeholders.
Strategic Issues and Management	Maintaining relationships with stakeholders and federal programs. Secretariat to F/P/T Advisory Committee on HIV/AIDS Secretariat NAC-AIDS A National Research Planning process Coordination of federal international HIV/AIDS initiatives Strategy for private sector involvement in NAS	Timely and strategic advice on emerging trends and issues. Increased strategic planning, effective policy advice, coordinated departmental responses to questions, for example House of Commons, Q&As. Enhanced national coordination of strategic policy and program development. Established planning principles and mechanisms for coordination of research activities in Canada. Increased and coordinated collaboration by Canada in international HIV/AIDS efforts. Increased private sector involvement in HIV/AIDS activities.

---

[16] Goal # 3 refers to searching for effective vaccines, drugs and therapies. CSC is not responsible for any activities in this area.

[17] The goal of effective implementation of Phase II of NAS applies to all components in the evaluation, including CSC, therefore it has been added here

Monitor, Review and Provide Advice on Implementation of the National AIDS Strategy as a whole	Financial accountability system. Implementation plan and annual NAS progress report Evaluation Framework, Mid-term Evaluation and Final Evaluation	Strategic management of NAS-II resources based on accurate and current financial data. Identification of barriers to effective implementation. Effective implementation of federal commitments consistent with NAS-II goals themes and intended impacts. Sound basis for developing NAS-II implementation plan and for evaluating NAS-II. Evaluation increases knowledge of NAS-II impacts and effectiveness, and provides guidance for future federal HIV/AIDS programming.

Policy Development:

In the area of policy development CSC's objective is to *revise existing policy statements and develop new policy statements on HIV/AIDS reflective of CSC's response to the recommendations of the ECAP.*

CSC's role is to set policy and program standards and specifications and to review the products developed to ensure that these standards are met. Policy development and revisions are on-going. HIV/AIDS is considered in all new or revised CSC policies, particularly as they relate to the delivery of health care services.

> **Commissioner's Directive CD-821 -Management of Inmates with HIV** was redrafted based on the ECAP recommendations, to reaffirm CSC policy respecting housing of inmates with HIV infection or AIDS in the general population and of not limiting their activities. It broadens the policy objective so that it may provide direction as to the prevention and control of infections in institutions and provide the appropriate support and treatment of staff and inmates with infectious diseases. The revised CD was promulgated. This same directive is again under revision to respond to further developments, including the need develop a Commissioner's Directive that encompasses a broad range of issues on infectious diseases including HIV/AIDS, and in response to the recommendations of the internal review of CSC policies, to incorporate requirements respecting staff, and to provide greater clarity in a number of areas.
>
> **Commissioner's Directive 803- Consent to Health Care Assessment, Treatment and Release of Information.** Commissioner's Directive 803 was amended in May 1995 response to ECAP's recommendation to reaffirm and strengthen CSC policy on confidentiality of inmates HIV status except where the CCRA provides for disclosure of an inmates HIV status without consent in circumstances where the inmate's behaviour constitutes a serious or immediate threat to himself/herself or others in the penitentiary or the community.
>
> **National Guidelines for Bleach Kit Distribution** were developed by a national Working Group to ensure consistent implementation of the bleach distribution program.

Program Delivery and Evaluation:

CSC's objective in this area is to *undertake or fund specific projects in inmate education, staff training, research, treatment, and support of HIV-positive offenders and in related areas, in pursuit of the goals of the National AIDS Strategy, and as required by CSC's Action Plan in response to ECAP.*

Epidemiologic monitoring:

This refers to national surveillance and other special epidemiological studies on HIV/AIDS and HIV/AIDS outbreak investigations. Health Services collects data on the reported number of cases of HIV/AIDS on a monthly basis. These activities help understand the HIV/AIDS epidemic and transmission patterns in federal institutions. They provide information to guide HIV/AIDS program design and delivery and to respond to inquiries from the public.

> **An outbreak investigation** is being conducted in collaboration with Health Canada and provincial health officials in an institution where an inmate died of AIDS after disclosing that he had shared needles with a number of other inmates.

Research and Evaluation:

CSC's role in the area of research and evaluation is a dual one. The first is to evaluate the pilots and developmental projects it undertakes. During the initial stages of development, Health Services should have had a more intensive, iterative process to identify the research and effectiveness evaluation component of programs. This is an issue of importance, as it underlies CSC's ability to effectively address long-term issues regarding prevention efforts. This issue is addressed further in Chapter under the heading - monitoring and evaluation.

Equally important is research into HIV/AIDS in prisons. CSC has supported general research on aspects of HIV/AIDS transmission in prisons and prevention in correctional settings. This research was conducted either internally and/or by external researchers.

> **National Inmate Survey:** CSC continues to acquire information to increase an understanding between injection drug use and other high risk behaviours and HIV transmission in Prisons. A series of questions were included in the National Inmate Survey conducted in 1995 to solicit information on high risk behaviours. The preliminary results confirmed that inmates do engage in high risk behaviour while incarcerated. Further analysis by CSC's Research Sector should serve as the basis for further research and to direct CSC's HIV/AIDS programming
>
> **HIV/AIDS, Injection Drug Use, and Harm Reduction in Prisons: A Review of the Literature** was initiated under contract to examine harm reduction practices internationally. CSC did not support a pilot of needle exchange in its response to ECAP, however is presently studying efforts made in other countries to help prevent the transmission of disease. This information will inform decision-makers.
>
> **HIV/AIDS in Prisons Discussion Paper-** was a project jointly funded by CSC and the Care, Treatment and Support Program. The Canadian AIDS Society and the Canadian HIV/AIDS Legal Network managed the project. The project first developed a discussion paper entitled *HIV/AIDS in Prisons Discussion Paper*. The paper focuses on the legal and moral obligation of governments to allow prisoners to protect themselves against HIV even if they engage in illegal and forbidden behaviours and addresses the issue of

potential liability for not providing condoms, bleach and sterile needles, and the resulting transmission of infection in prison. This paper was a precursor to the broader joint research project which assesses, prioritizes and addresses key HIV/AIDS legal and ethical issues in Canada. Community-based AIDS and prisoner organizations, members of the legal community, provincial governments and other stakeholders were consulted. This stage of the project resulted in the Final Report on HIV/AIDS in Prisons. This Report provides an update on developments since the ECAP Report and provides a "report card" on CSC's response to the ECAP Report.

Evaluation of the Dorchester Peer Education Project was conducted as a condition of the contract with AIDS New Brunswick.

Matsqui Bleach Distribution A research questionnaire was developed in collaboration with the BC Centre for Excellence in HIV/AIDS to track participation, the use bleach was put to and the impact of bleach distribution on risk behaviours. CSC's Executive Committee decided to proceed with national implementation of the bleach distribution kits without the benefit of a formal evaluation of the Matsqui pilot. As discussed later, an evaluation may have provided some insights that would have informed the national implementation. Health Services has not established an evaluation framework for the national bleach kit distribution project, consequently, there has been no pre implementation information collected, for pre-and post test comparative purposes, which will make it difficult to attribute behaviours to the implementation of bleach.

Inmate Education:

CSC agreed with ECAP recommendations that educating inmates about HIV/AIDS and about drug use is an important aspect to promote and protect their health. Education opportunities are offered to inmates. NAS-II provided funding in support of the production and distribution of a number of education resources for inmates:

Finding Out: What you need to know, a comprehensive information manual for inmates living with HIV/AIDS was disseminated to all Chiefs Health Services for distribution to known HIV positive inmates and available to other inmates. This publication was developed under contract by a researcher from the University of Toronto. It is a manual or living guide for men and women with HIV, providing comprehensive and easy to read information on medical, legal, financial problems and issues which they will encounter during the course of the disease.

Preventing HIV and Hepatitis Infections in Federal Prisons and **Living with HIV, AIDS or Hepatitis in federal prisons,** are two bilingual video presentations targeted to CSC institutions. These video resources, as well as the manual -Finding Out- were also found to be in demand by provincial corrections and agencies working in the health or corrections fields, and to community-based AIDS organizations across the country who have offenders and ex-offenders as clientele.

The Federal/Provincial Health Education Project in the Pacific Region was funded, in part, by CSC and the Corrections Branch, Ministry of the Attorney General of the province of British Columbia. An educational program entitled "the Challenge of Choice", a health promotion program advocating healthy lifestyle choices was to all inmates and staff in federal and provincial institutions in British Columbia with the intent that it serve as a model for CSC in other regions. CSC contributed $50,000 annually for two years under National AIDS Strategy Funding toward a federal/provincial health information program in the Pacific Region. This funding supported the salaries for 1.5 health educator positions and related project expenses related to travel, clerical support, educational materials and supplies, and related miscellaneous expenses. The principle nurse educator recruited to implement the project was a CSC employee. This cooperative effort between CSC-Pacific and the province of B.C. saw provincial and federal inmates in British Columbia provided with health education sessions, workshops and seminars addressing current concerns including infectious diseases such as HIV/AIDS, Tuberculosis, Hepatitis B and C, delivered over the course of 12-18 months. The resources were reproduced for all five CSC regions. A number of provincial jurisdictions also purchased the manual for use in their institutions.

C.A.N (Cons AIDS Network) pilot project - a National Pilot Inmate Peer Education Project was initiated in February 1995, under contract to AIDS New Brunswick/SIDA Nouveau Brunswick and was developed implemented and evaluated as a pilot at Dorchester Penitentiary, a medium security facility for men in New Brunswick. The overall goal of the project was to develop, implement and evaluate a sustainable peer education model in which inmates provide others with the necessary information, motivation and skills to prevent HIV and other communicable diseases, as well as to provide support to those already infected. The expected results of the program included increased knowledge, improved attitudes toward risk reduction behaviour and persons living with HIV/AIDS and increased rates of HIV risk reducing practices and health promoting behaviours in inmates.

Essential elements of the project included the development of criteria for participant selection, the development of job descriptions for the paid peer education coordinator and the volunteer peer educator, trainee evaluation and training curriculum evaluation design; the development and administration of a pre and post- training Knowledge, Attitude and Behaviour questionnaire; and finally program evaluation and the drafting and dissemination of a final report. A final report was submitted in December 1996. The evaluation of the project supports the efficacy of inmate peer education models in relation to preventing the spread of HIV and other communicable diseases within prisons as well as providing support to those already infected. To facilitate adaptation of the C.A.N. project to other institutions, a comprehensive training manual was developed as guidelines for setting up, implementing and sustaining peer education and support programs within correctional facilities. National implementation is pending.

Handout on HIV/AIDS and Substance Abuse. In support of the ECAP recommendation that education about drug use is an important element in efforts to prevent transmission of HIV, the National HIV/AIDS Coordinator worked with the Substance Abuse Program staff to produce a information handout on HIV/AIDS and substance abuse for inclusion in the Drug, Alcohol, and Personal Choice Program.

Prevention:

CSC's objective is to increase the availability of prevention measures to offenders.

In support of this objective CSC has funded, with NAS-II resources, the bleach distribution program, first through a pilot, followed by national implementation.

> **Pilot of Bleach distribution at Matsqui Institution, a medium security facility was launched in December 1994 with the appointment of a full-time institutional project coordinator.** Bleach is a key preventive initiative in the transmission of HIV, to clean needles, tattoo and piercing equipment and any other tools used to inject drugs. While CSC does not condone illegal activities, it has agreed in the interests of public health responsibility to implement infection control measures such as bleach kits to reduce harm. The CSC pilot tested the distribution of bleach kit with specific step-by-step instructions on how to safely clean needles, tattooing and piercing equipment.
>
> **National Implementation of Bleach Kit Distribution.** In April 1995, CSC's Executive Committee approved national implementation following preliminary results of a pilot project at Matsqui Institution. The Matsqui pilot was never fully evaluated. Stringent implementation guidelines, a marketing strategy for staff and inmates, a bleach kit distribution education package and policy direction was developed and distributed in 1996. The program was implemented nationally in September 1996.

Care, Treatment and Support:

This refers to providing care, treatment and support services to offenders living with HIV/AIDS during incarceration and planning for post-release. The objective in the case of conditionally released offenders is to increase the accessibility of post-release services to offenders living with HIV/AIDS:

> During 1995/96 CSC undertook preliminary work to develop the implementation strategy for an anonymous HIV testing program as recommended by ECAP. Inmates were provided with information to increase their awareness of the importance of voluntary HIV testing and CSC Health Services staff were provided with resources to increase their knowledge and comfort level with the issue of HIV testing.

Staff Education:

To provide staff with the education and training necessary to deliver appropriate care, treatment and support services to offenders as well as to protect themselves from transmission.

Staff training is an important component of CSC's National AIDS Program as it supports program development. To respond effectively to the needs of HIV infected inmates requires sensitivity and, in the case of health services staff, the professional skills to intervene appropriately. While no specific staff training programs were introduced during NAS-II, training of staff is an on-going endeavor at the regional and institutional levels.

> **CSC's orientation program for all new staff** provides training on infectious diseases to all new recruits to the Service. The training module consists of a half day session, and is usually delivered by external expertise such as Health Canada.
>
> **Refresher training** is provided periodically. Generally training has fallen on Health Services staff, although Health Canada or other external resources are used on occasion.

Health Services is responsible for disseminating professional information and training materials developed either in-house or externally to its regional and institutional staff. Health Services also ensures that the training materials, manual and guidelines developed during pilots are disseminated to all CSC staff on national implementation.

Clinical staff have been provided self-teaching materials on the new developments in the management of HIV/AIDS as they become available:

> **Pamphlets on HIV and Tuberculosis,** produced by the Canadian AIDS Society (CAS) were provided to the institutions in 1994.
>
> **Practice guidelines** series produced by Health Canada in cooperation with the Canadian Medical Association, such as the Counseling Guidelines for Human Immunodeficiency Virus Serologic Testing, have been disseminated to institutional health services staff;
>
> The **HIV/Pre-Post Test Counseling Checklist, developed by Health Services staff at National Headquarters** was issued to the field in March 1995. The checklist, based on the Counseling Guidelines for Human Immunodeficiency Virus Serologic Testing of the Canadian Medical Association was intended to replace other checklists in use to promote a consistent approach to counseling.
>
> **Federal/Provincial health education project** in the Pacific Region (see above)

Issue Management:

The objective of issue management is to develop and maintain expert knowledge and analysis of AIDS issues in federal prisons as they emerge; develop and maintain partnerships and networks in the AIDS and public health fields; provide input to communications plans or materials developed for the media on AIDS in CSC facilities.

The following is an example of some of the partnerships that CSC has fostered during NAS-II.

Promoting Partnerships:

Federal/Provincial health education project in the Pacific Region between CSC and the province of British Columbia. CSC shared overhead costs with the province. This project represents a small but effective example of federal/provincial cooperation and shared jurisdiction.

First National HIV/AIDS in Prisons Workshop sponsored by the Prisoners with AIDS Support and Action Network PASAN). CSC National AIDS Program, along with the AIDS Community Action Program of Health Canada assisted the Prisoners with HIV/AIDS Action Network (PASAN) in the development of a funding request to Health Canada in order to hold a national workshop in August 1995. CSC also contributed to the cost of two workshop planning committee meetings and to the travel costs for CSC staff and inmate participation in the workshop. The workshop brought together front-line health workers in prison and community groups as well as prisoners and ex-prisoners in order to:

- provide a forum to discuss issues regarding HIV/AIDS in prisons;
- provide strategies to encourage partnership development and net working of education, support and advocacy efforts on a national basis;
- to call attention to common factors linking Tuberculosis, hepatitis and other communicable diseases with HIV in correctional settings and the need for an integrated approach.

Matsqui Bleach Pilot included representatives from AIDS Vancouver on the steering committee. They provided knowledge and expertise. CSC worked with the British Columbia Centre for Excellence in HIV/AIDS to develop a questionnaire to track participation in the pilot and monitor the use bleach is being put to and impact on needle cleaning behaviour. The subsequent national implementation of bleach also involved the Union of Solicitor General Employees (USGE) and the Professional Institute of the Public Service (PIPS).

National Pilot Inmate Peer Education Project at Dorchester Institution is an example of the role that Community-based AIDS organizations can play in the area of program delivery. The project involved a variety of key players. The institutional project coordinator worked with a national advisory committee consisting of representatives from CSC, Health Canada, John Howard Society, various AIDS service organizations and inmates. Inmates infected with or affected by HIV/AIDS played an instrumental role throughout all phases of the project.

CSC contributed funds to an **Infectious diseases in a correctional setting symposium** hosted by the Canadian Public Health Association (CPHA) in November 1994 and assisted in the planning of the symposium. The goal of this hosted/invitational symposium was to educate correctional staff on the current practices for the identification, prevention and treatment of infectious diseases in correctional facilities. Conference invitees included correctional health care personnel and administrators from each province and the CSC. SmithKline Beecham (SKB), a pharmaceutical company, co-funded the conference.

Federal/Provincial/Territorial Heads of Corrections Working Group on HIV/AIDS Recently, and in response to the concerns raised in the HIV/AIDS in Prisons Final Report (Jurgens), CSC has taken a leadership role in initiating collaboration with provincial and territorial correctional officials by establishing a Federal/Provincial/Territorial Working Group. The mandate of the Working Group will be to promote the policy and program environment that will enable provincial/territorial and federal corrections systems to address HIV and AIDS in the prison environment through examination of the issues and the opportunities for collaboration.

Additionally, partnerships have developed locally, for example:

> **A Conference** in Quebec Region in February 1996 involved a number of key organizations including representatives of L'Office des droits des détenus, to look at preventive measures as well as ways to deal with those affected by the disease;
>
> **Provision of Prevention Education by Central Alberta AIDS Network Society** in Bowden Institution.

3.3 PLANNED ACTIVITIES

In preparing a response to the Final Report on AIDS in Prisons, CSC has agreed to undertake an examination of a number of issues , including some which, in response to ECAP, it was not willing to undertake previously. Plans are to undertake some of these activities in the last year of NAS-II funding. The key activities being pursued in the next few years have been outlined in Chapter 4.1 - Relevance and Continued Need.

4. ASSESSMENT OF CSC'S PARTICIPATION IN THE NAS-II

This chapter presents the evaluation findings related to CSC activities under the NAS-II. Evaluation results are discussed as they relate to the major evaluation headings: relevance and continued need; objectives achievement and success; and, cost effectiveness and alternatives.

4.1 RELEVANCE AND CONTINUED NEED

Relevance:

The on-going relevance of CSC's National AIDS Program as well as considerations of what form, if any, the program should take in the future, were examined. Given CSC's role and responsibilities as an operational agency to provide health services to federal inmates, the issue of relevance is whether CSC's activities under NAS-II are consistent with the overall objectives of NAS-II.

HIV has become a public health threat to the whole community. It is, however, much more common among those who engage in certain high risk behaviours, such as injection drug use and unprotected sex. The HIV epidemic among intravenous drug users in Canada is continuing to increase at an alarming rate. One vulnerable group is Canada's inmate population, especially because many are known to have histories of drug use. Evidence points to rates of HIV/AIDS infection in the prison population as much as ten times greater than in the population at large. Since the onset of the initiative in 1993, there have been growing numbers of reported HIV/AIDS infected inmates in CSC institutions. All but one institution reported, to their knowledge, having an HIV infected inmate in their population at some point in time. As of the end of March 1997, there were 149 inmates known to be HIV positive living in our penitentiaries.[18]

Epidemiological information on HIV/AIDS among Aboriginal peoples in Canada presented by the Laboratory Centre for Disease Control, suggests higher rates of HIV among the Aboriginal population. and a likely increased risk for HIV infection because of their socioeconomic situation and relatively high rates of sexually transmitted diseases.[19] It has been suggested that Aboriginal women will represent the next epidemic due to the high rates of intravenous drug use. This is of relevance to CSC and its National AIDS Program, since Aboriginal inmates represent 18% of the inmate population and are therefore over represented in CSC institutions relative to their representation in the general population.

---

[18] Correctional Services of Canada, , Monthly reported cases of HIV/AIDS in Federal Penitentiaries. Ottawa: CSC, Health Services Branch. March, 1997

[16] Health Canada. Laboratory Centre for Disease Control. Epi Update - HIV/AIDS Epidemiology Among Aboriginal Peoples in Canada. Ottawa: November 1996.

Evidence also points to the fact that inmates continue to engage in high risk behaviours while incarcerated. In the 1995 Inmate Survey inmates self-reported on their high risk behaviours. Overall, 26% of respondents reported engaging in risky behaviours such as needle sharing, tattooing, or unprotected sex. These behaviours present a strong possibility of transmission of HIV during incarceration.

Over 80% of all inmates in federal penitentiaries are serving fixed sentences and will eventually be released back into the community. Federal institutions are essentially "passage-ways" for the flow of high risk individuals in and out of the community. This means that the consequences of high-risk behaviour within the institutions will impact on the community general population at large. Steps taken inside to protect against the spread of HIV, therefore, ultimately does serve to protect the general public.

The complex issues surrounding the spread of HIV are magnified in a correctional environment. They cover the spectrum of medical concerns relating to the management and provision of health services to infected inmates, legal, moral and ethical concerns, as well as issues of institutional security, confidentiality, the protection of human rights, and the potential risk to public health. More specifically:

- as numbers of HIV and AIDS cases increase, there will be an increased requirement/demand for HIV/AIDS education, prevention, counseling and other health services resources. There will be increased costs associated with treatment. The costs of treatment have escalated with the advent of the third generation of HIV-treatment drugs - the protease inhibitors - with significant monthly costs but which leads to the management of HIV as a chronic disease with certain patients;
- discrimination and stigmatization of HIV infected or at risk persons and the management of such situations;
- dealing with the fear of HIV/AIDS on the part of staff and offenders;

- increased possibility of transmission of disease to staff in the event of exposure to blood or body fluids; and,
- for Canadian Society there is increased likelihood of transmission of disease by infected ex-offenders with the attendant financial and social burdens.

CSC's role as an operational agency has largely defined its focus and priority areas for action. The Service has focused on a number of initiatives in the areas of prevention, education of both staff and inmates, treatment and care, and research. These responsibilities are aligned with CSC's legislative mandate (*Corrections and Conditional Release Act;* sections 85 to 89), its Mission and Health Services responsibility to provide inmates with "appropriate, equitable, and adequate access" to professional health care. A review of the nature and diversity of CSC's activities indicates that, as an operational agency serving a unique clientele, CSC's activities under NAS-II clearly support the overall objectives of NAS-II: preventing the spread of HIV/AIDS and providing care, treatment and support for those infected or affected by the disease.

Continued Need:

CSC's commitments and activities in response to ECAP provided a comprehensive response to HIV/AIDS and an appropriate balance among the activities under NAS-II. It was observed, however, that as a consequence of organizational and staff changes, CSC has progressed more slowly than originally planned and this has shifted this balance so that it will be difficult to implement all of accepted recommendations before the National AIDS Strategy - Phase II ends in March 1998.

The HIV/AIDS in Prisons: Final Report (Jurgens, 1996) judged CSC's response as failing to adequately address the issues raised by HIV/AIDS and drug use. To a large extent this criticism is directed at CSC's rejection of critical ECAP recommendations in the area of harm reduction, as well as uneven implementation of some of the accepted recommendations.

CSC staff were consistent in their identification of the predominate areas requiring future attention:

- staff and inmate education and refresher training, including education and training for professional staff (78%)
- improvements to care, treatment and support (67%)
- further expansion of harm reduction measures such as needle exchange (56%).
- a small number of respondents (4%) identified the availability of methadone as an area requiring examination.

Health Services, in developing CSC's response to the Jurgens Report, has begun to address most of these issues. As a necessary first step, CSC has developed a program framework[20] that outlines a comprehensive response to HIV/AIDS in federal corrections. The framework builds on the work already completed or initiated under the NAS-II and identifies a number of key areas on which the Service must focus its attention in the upcoming years if it is to respond in a balanced and effective way to HIV/AIDS.

The following provides a summary of work to be initiated or yet to be completed:

Education and training of staff and inmates.

Additional staff education, including specialized education for health professionals in such areas as pre- and post-test counseling, and caring for inmates with HIV/AIDS was clearly identified as a need. In the absence of a general staff education effort, it will continue to be difficult to implement some of the more controversial ECAP and Jurgens recommendations. Effective staff education programs are necessary precursors to successful implementation of HIV/AIDS initiatives.

CSC plans to undertake the following initiatives in relation to staff training:

- update existing training materials such as the Correctional Training Program modules on infectious diseases and substance abuse;
- assess training needs of all staff working with offenders in the institutions and the community, and develop a training strategy to address needs;
- educate and train Case Management staff and National Parole Board members on Parole by Exception for offenders suffering from terminal illness; and,
- identify professional development needs for nursing and medical professionals and provide them the education opportunities to address these needs.

Staff were also agreed in their assessment that additional inmate education is required. For many inmates the period of incarceration may be the only real opportunity for access to education on infectious diseases, consequently the potential benefits of providing education opportunities to offenders has positive spin-offs for behaviour while in the community.

CSC plans to promote the on-going education of offenders through the following activities:

---

[20] Correctional Service of Canada. A National Framework to Address HIV/AIDS in Prisons (draft). February 1997.

- sessions delivered with the assistance of inmate peer counselors and with input from community-based AIDS organizations. A model for peer education has been developed in the Atlantic Region through NAS-II funds. CSC will evaluate the Atlantic model, as well as other models developed elsewhere, to define a nationally consistent standard for the implementation of the Dorchester or similar peer education program nationally. The peer education model will be adapted to meet the needs of Aboriginal and women offenders;
- assessing the currency of existing inmate education resources and, if the need exists, developing additional education resources; and,
- introducing education modules about HIV and substance abuse into the security and substance abuse programs.

Expansion of Harm Reduction Measures:

In 1994, CSC rejected a number of the harm reduction recommendations contained in the ECAP report, including authorizing tattoo equipment and supplies in the institution, providing methadone maintenance programs, and pilot testing a needle exchange. CSC, in responding to the recent Jurgens Report has reexamined its position with respect to these measures and has indicated that it will:

- assess the operational requirements and implications of permitting qualified offenders to provide tattoo and body piercing services as an inmate operated business;
- examine the issues around methadone, including maintenance, in a correctional environment, including staff acceptance, resource requirements, admission criteria, access to therapy, and options for inmate participation. In addition, the effectiveness of CSC's existing substance abuse programs will be assessed; and,
- assess the experience of other jurisdictions with respect to needle exchange, and its feasibility for CSC.

Pilot projects are planned in each of the above areas.

Care, Treatment and Support and Health Promotion Activities.

Health promotion and disease prevention have been identified as a primary activity for Health Services staff, as well as ensuring appropriate, equitable and adequate access to professional, physical and mental health services.

Treatment and care varies among institutions, reflecting variability in locally available services. To the extent that services are available in the community, physicians are encouraged to refer offenders to specialist services.

In the area of care, treatment and support CSC plans to:

- strengthen its health promotion focus. It will provide nursing staff with the necessary training and tools to provide health promotion and prevention strategies;
- as treatment entitlements are not uniform across the country, Health Services plans to develop guidelines for the standards of care for the HIV/AIDS infected inmate;
- CSC plans to promote existing testing options and examine all options available to inmates at reception and during incarceration. In addition, CSC has reaffirmed a commitment it made in response to the ECAP Report that it will pilot anonymous testing and assess the feasibility of national implementation. The key to the successful implementation of testing options is increasing the quality, accessibility and acceptability of testing education and counseling by Health Services.

Closely related to the issue of testing is the issue of confidentiality and disclosure of offender medical information pertaining to HIV testing and HIV status. CSC is assessing current policy guidance and provide legally viable and clear direction to staff in this area.

Research into Seroprevalence:

CSC plans to conduct a number of initiatives to build on its current knowledge about HIV/AIDS in order to further support Executive Committee decision-making on program planning and resourcing. Specifically, CSC has commenced or will be commencing the following activities:

- in partnership with Health Canada, examine the feasibility of undertaking a major, national seroprevalence study to obtain estimates of the rate of HIV and Hepatitis in federal institutions, and the extent of risk behaviours on transmission. Results will inform policy and program direction;
- evaluate the effectiveness of the bleach distribution program, and condom distribution;
- further analyze the results of the Inmate Survey;
- in collaboration with Health Canada, develop a database for monitoring and surveillance of HIV and AIDS cases in prisons.
- in partnership with Health Canada, Laboratory Centre for Disease Control, conduct an epidemiological investigation into an incident in one institution where the risk of transmission of HIV was judged to be high after HIV positive inmates were found to be engaging in high risk behaviours.

Addressing the Needs of Special Interest Groups:

To date, CSC's work in the area of HIV/AIDS has focused on program development for the offender population generally. Specific initiatives that have been undertaken with respect to Aboriginal and women offenders have occurred at the regional and institutional levels. CSC agrees that it should do more to ensure appropriate education and training and other specialized programming is available to these inmates. Aboriginal Programs and Federally Sentenced Women are taking the lead on these initiatives with assistance from Health Services.

While CSC has committed to a balanced response through accepting the majority of the ECAP recommendations, achieving that balance means that the Service must effectively implement these recommendations. To do so will require additional effort, particularly in the areas of education for staff and inmates and harm reduction program development for inmates.

There is a concern that a number of activities may not be sustainable in the absence of a federal role and funding support through the National AIDS Strategy. When asked what would not be sustainable there was an almost equal distribution of responses among research and development activities (55%), education and training for staff (55%), education and training for inmates (52%) and expansion of harm reduction measures (59%). Information sharing activities were also identified by some respondents (37%) as not sustainable.

NAS-II has enabled CSC to focus on HIV/AIDS in practical and concrete terms. Perhaps the strongest feature of CSC's response to the overall objectives of NAS-II has been in the expansion of harm reduction measures for inmates through the implementation of bleach distribution. There is evidence, however, that the effectiveness of bleach in preventing transmission is limited, largely due to inadequate technique in using bleach. Planned program development efforts (through pilots) should expand on these efforts and contribute to additional, more effective harm reduction measures such as needle exchange, methadone maintenance and tattoo and body piercing services for inmates.

CSC plans for future years include a wide range of activities to improve its response to HIV/AIDS. Should these activities be pursued, the Service will require the resources to support the development and implementation of these initiatives, through either the reallocation of CSC funds, or through initiative funding. It is also imperative that CSC ensure continued support for established services and allow for their expansion with increased demand.

Summary and Conclusions:

The Service, as a operational department responsible for providing health services to offenders, has no option but to respond to HIV/AIDS. As a federal department it also has an important national leadership role and contribution to make to an understanding of HIV/AIDS in a carceral environment.

The demand for additional programming and activities in the area of infectious diseases, including HIV/AIDS will increase with the number of offenders living with HIV/AIDS, and as more and more staff deal with these offenders. There is a clear consensus, both among health services staff, and external critics[21] that HIV/AIDS is not being adequately addressed by CSC, and that efforts must be continued to respond more effectively to individual cases of HIV infection, to better understand transmission in penitentiaries and to address the underlying issues associated with HIV/AIDS in prisons.

In all likelihood, CSC will not be able to complete its planned initiatives under NAS-II, given the scope of the work that it has left to do, nor would the last year of NAS-II funding be sufficient to carry out all the planned initiatives. Expenditures associated with the developmental aspects of the program are extremely high and these costs are the least likely to be absorbed. In the absence of initiative funding, resources will have to be found from within the existing resource bases of the Sectors involved. The initiatives under the National AIDS Program will therefore be competing with other corporate issues for limited resources. There is a danger, therefore, that work will not be completed.

4.2 IMPLEMENTATION AND OBJECTIVES ACHIEVEMENT

The ECAP report provided a series of recommendations to improve CSC's response to HIV/AIDS. CSC "reacted" to each recommendation, rather than developing a comprehensive CSC program to respond to HIV/AIDS. In retrospect, the lack of strategic planning at the onset of NAS-II contributed to CSC's subsequent difficulty in responding to the issues.

---

[21] Both the Expert Committee on AIDS in Prisons Report, and more recently the Final Report on AIDS in Prisons were highly critical of CSC's lack of progress in addressing the issue of HIV/AIDS in prisons.

Impact analysis of the ECAP Report Recommendations:

The Service appears to have publicly committed to a number of the more controversial recommendations without fully assessing the operational and cultural impediments to successful implementation. As a result, the Service may have underestimated the complexity of the issues and not fully anticipated the dichotomy between a correctional/security model and a prevention/harm reduction model and the impacts that this dichotomy would have on implementation.

This combined with the lack of an integrated, partnership approach and structures to facilitate implementation, the Service may have been overly optimistic in its commitments and estimates of timelines for implementation. As a result, the Service has been, and continues to be, vulnerable to criticism for not responding quickly enough to HIV/AIDS and not fulfilling promises. In the future, CSC should commit to initiatives only after full consultation and an analysis of the impacts and impediments to implementation at the operational level.

The need for a integrated corporate framework, strategic approach and accountability framework:

It has been observed that the Service's response to the initiative is more reactive than proactive - a "Band-Aid" approach that does not get to the root of the problem." Its response has been to carry out a series of activities, largely in reaction to each of the ECAP recommendations, as opposed to developing a broad-based program strategy, seeking out obvious places to build partnerships and working with existing corporate structures to further advance its mandate under NAS-II.

CSC failed to develop a broad-based strategy, seeking out "obvious places to build partnerships and working with existing corporate structures to further advance the CSC mandate under NAS-II

Perhaps CSC's greatest difficulty in developing an effective response to HIV/AIDS has resulted from the failure to take a strategic approach to the issue of HIV/AIDS in federal correctional institutions, and the absence of a corporate framework to address the multi-dimensional nature of the issues. This may be a partial consequence of the absence of a strategic planning and priority-setting process at the national level that involved all levels and sectors of the organization.

Regions, institutions and other National Headquarters Sectors reported that they have not been significant contributors in the establishment of corporate priorities in responding to HIV/AIDS. For example, most institutional staff (63%) reported that they had not been consulted on the planning, establishment and review of national HIV/AIDS related activities; 81% rated the extent to which they were consulted as limited or not at all. In fact, staff in other National Headquarters sectors, and institutional staff, were often not aware that Health Services had received funds from Health Canada for HIV/AIDS related activities.

Decision-making about program priorities, activities, and the allocation of resources was, therefore, concentrated at National Headquarters, Health Services. Decisions were generally made in the absence of input and problem definition from either the regions or other sectors at National Headquarters. Other components of CSC were not provided the opportunity to submit proposals for projects to address non-health services or regional issues. Regional and institutional activities, therefore, have been defined solely on the basis of the priorities established by Health Services at National Headquarters. This approach may have adversely affected corporate "buy-in" and has made it difficult to develop an integrated corporate response to HIV/AIDS.

Decisions on programs and resource allocations were made in the absence of regional input or problem definition.

Additionally, there was no infrastructure created for regional and local administration of the program, nor clear roles and responsibilities established to ensure implementation, the monitoring of the program's progress and accountability, particularly at the local level.

National Headquarters is ultimately accountable for the expenditures under the Strategy and for ensuring a coordinated and consistent response to HIV/AIDS across the regions. Accordingly, National Headquarters believes it should retain the authority to define which issues should be addressed. Regions and other National Headquarters Sectors, however, should have an opportunity to identify their needs and, based on these needs and the requirements of the initiative, assist in the planning, development, implementation and monitoring of a coordinated national response to HIV/AIDS.

RECOMMENDATION TWO:
Should Health Services receive funding from a renewed NAS, it should continue to encourage internal partnerships in the National AIDS Program. Health Services should consider establishing processes

- **to seek innovative proposals for HIV/AIDS related activities from other sectors, regions and institutions (e.g. call letter to National Headquarters Management Committee, and Executive Committee); and,**
- **to review, approve and resource them.**

It should be noted that Health Services has recently begun to address these issues through the development of a strategic framework and a comprehensive corporate response through:

- the development of a corporate program framework that clearly defines accountabilities; and,
- the establishment of an Implementation Committee; and Regional Infectious Diseases Committee, chaired by the National HIV/AIDS Coordinator, and supported by subcommittees.

A national Implementation/Working Committee was established in January 1997, with representation from all National Headquarters Sectors, as well as from all five Regions, to develop a program framework to respond to HIV/AIDS in CSC. The Program framework[22] recognizes that the multi-dimensional nature of substance abuse, treatment and harm reduction strategies and HIV/AIDS requires a multi-faceted and collaborative organizational response. The framework includes an accountability structure to maintain a focus on HIV/AIDS, and to establish a commitment on the part of CSC to focus attention to respond to issues of HIV/AIDS. The strategy clearly defines the roles and responsibilities of all sectors and levels of the organization in implementing various aspects of the program.

Recognizing that the key to effective implementation resides at the operational level, a more clearly defined role is planned for regions and institutions. Due to the complexity and multi-disciplinary nature of the National HIV/AIDS Program, full implementation is recognized as requiring concerted, consistent and dedicated effort and resources. To demonstrate commitment for the delivery of the National HIV/AIDS Program, consistency in approach and accountability for implementation, Health Services at National Headquarters has asked each Region and each institution to designate an individual who will be responsible for coordination of the HIV/AIDS and infectious disease initiative.

---

[22] Correctional Service of Canada. A National Framework to Address HIV/AIDS in Prisons (draft), February 1997.

The Regional Coordinators will represent their respective Region on the Committee of Regional Infectious Diseases Coordinators.

In assigning staff to the positions of regional and institutional infectious diseases coordinator, it will be important to define accountability fully and assign it carefully. In assigning accountability and responsibility for results, the individual must have the authority, the resources, skills and knowledge to carry out the required activities. CSC will need to ensure that clear role statements exist for these positions and as CSC's national strategy evolves, that changes to the roles and responsibilities correspond with the natural evolution of the program.

At the onset, National Headquarters should exercise a strong leadership role in establishing program standards and providing the framework for implementation. Once Regions feel comfortable they can execute CSC's mandate under the initiative and respond to their own regional needs under the program, greater responsibility should be transferred to the regions. It should be noted that regional strategies need to be consistent and complementary to the national objective and the priority areas in order to implement the strategy effectively.

In addition to the National Implementation/Working Committee and the Regional Infectious Diseases Committee, a number of subcommittees have been formed to examine and advance the issues of research, methadone, anonymous testing, needle exchange. As well some regions have established regional infectious diseases committees.

Health Services has recognized that the complexity and nature of HIV/AIDS in CSC calls for a multi-disciplinary organizational response and that effective strategic management of the initiative can only be achieved through a coordinated, corporate approach.

The regional members of the Infectious Diseases Committee are responsible for overseeing and coordinating the implementation of the national program in their regions. The National HIV/AIDS Coordinator should consider including, as part of this Committee's mandate, the examination of strategic issues and planning so that decisions on priorities and project funding more fully reflect organizational priorities.

The establishment of these Committees will likely improve internal coordination with other National Headquarters Sectors and the regions. Regional and institutional involvement and participation will greatly contribute to the furthering of CSC's agenda in response to HIV/AIDS.

To ensure that institutional staff have an opportunity to provide their input, Health Services should ensure that the role statements of the regional coordinators include a requirement to consult with the institutional coordinators within their respective regions.

The consultation process on the strategy and framework began in January 1997.

Some Regions have been more strategic than others in their response to HIV/AIDS. Ontario Region, for example, has a dedicated resource as the Regional Coordinator, Infectious Diseases who has developed and implemented a detailed, region-specific plan and chairs a Regional Infectious Diseases Committee, comprised of representatives from each institution. The Coordinator ensures compliance with policy requirements, provides training to staff and inmates, and is a resource to institutional staff on infectious diseases. The Regional Coordinator meets with the Chiefs, Health Services monthly to exchange information within the Region.

There are advantages of the Ontario model, including the following:

- the assignment of a full-time resource, with expertise in the area of infectious diseases, demonstrates a leadership and commitment to address the issues relating to infectious diseases. The incumbent is identified within the Region as having a lead role and accountability for implementing initiatives within the Region;

- the development of detailed implementation plans on behalf of the institutions in the Region reduces duplication of effort and ensures a coordinated and consistent approach to implementation in all institutions;

- institutions have a knowledgeable resource who can respond to any concerns that arise and who can assist them in implementation;

- the Regional Coordinator collects and provides information to the institutional staff. This single source ensures that staff are regularly updated on developments in the areas of HIV/AIDS and infectious diseases; and

- ensures accountability for monitoring policy compliance.

RECOMMENDATION THREE:

Health Services should share the Ontario experience with the other Regions.

Regions should examine the feasibility of a resource dedicated to addressing issues regarding infectious diseases.

Should the Ontario model be feasible elsewhere, consideration should be given to a multi-sectoral regional committee membership.

Coordination and Collaboration:

The Director General, Health Services, and the National HIV/AIDS Coordinator, are responsible for administering the funds and overall coordination of the program. Essentially, National Headquarters coordinates the program and policy development for the project and is responsible for establishing standards for program delivery, policies and protocols. National Headquarters' role vis-à-vis the regions is primarily to provide policy guidance, technical assistance and expertise on the planning, development and monitoring of projects undertaken by the Regions.

At the management level, Health Services has several forums whereby information on the National AIDS Program can be exchanged, issues raised and support sought at the management level. These include the Executive Committee, The Committee of Assistant Deputy Commissioners, and National Headquarters Management Committee. There was little evidence that these forums were consistently used by Health Services in the past to advance the HIV/AIDS agenda. More recently, however, Health Services has briefed the National Headquarters Management Committee, and the Committee of Assistant Deputy Commissioners on their planned initiatives.

As previously noted, until recently, formalized internal coordination mechanisms to ensure the flow of information and to effectively administer the initiative were not established. Within National Headquarters, various National HIV/AIDS Coordinators have relied primarily on informal networks. Ad-hoc committees were established to respond to specific issues.

Recently, however, Health Services has established several formal mechanisms to strengthen coordination and administration of the HIV/AIDS and, more generally, the infectious diseases initiatives. The Director General, Health Services has created a National Infectious Diseases Committee to advise Executive Committee on issues or initiatives related to infectious diseases. Internal representation includes Human Resources, regional senior management, and regional Health Services. To ensure that operational considerations are an integral component of any proposals put forward by the Committee, membership will be expanded to include a representative from operations. Technical expertise is provided by Health Canada representatives.

The Committee will assess issues, proposed initiatives or interventions as they arise, advise Executive Committee as to the preferred course of action, and identify the necessary resources to carry out approved activities. Because the Committee brings together key correctional players with external experts in the area of infectious diseases, it is viewed as the formal mechanism for interdepartmental and internal coordination.

CSC's slow response may have been partly due to a lack of collaboration between National Headquarters and the field on issues of implementation. However, coordination with the Regions improved greatly with the establishment of the National Working Group, tasked with implementing bleach kits and anonymous testing (1995). The decision to involve regional staff was one of the positive aspects to CSC's approach to introducing the bleach distribution initiative. While established to address issues of bleach kit and anonymous testing implementation, it also served as a vehicle to exchange information generally about HIV/AIDS. This approach was well received by the participants and undoubtedly has had positive impacts on effective national implementation of bleach kit distribution.

The Committee of Regional Coordinators, Infectious Diseases will greatly facilitate the exchange of information among Regions. Participants will be more informed and this will facilitate a coordinated, consistent, and uniform implementation of the accepted ECAP/Jurgens recommendations. The Committee has met once, and there have been several conference calls to discuss issues surrounding implementation. It is too early, however, to properly assess the effectiveness of this Committee.

The smaller sub-committees will also facilitate the exchange of information on specific initiatives.

Interviews with regional staff focused primarily on CSC's national/regional dynamic and respective roles. National Headquarters was perceived as having an important advisory role to play vis-à-vis the regions. The expertise and the linkages of the National HIV/AIDS Coordinator to Health Canada resources were seen as a valuable resource. However, some regions felt that Health Services had not always assumed a leadership role in providing information and direction on HIV/AIDS or in providing clear direction with respect to implementation requirements.

The lead role with respect to several of the key developmental initiatives resided with regional staff (e.g. pilots of bleach distribution, peer education, and development of a health promotion materials). It appears that roles and responsibilities in relation to the development of these projects were clearly defined and regional staff assumed full responsibility for carrying out these projects, with advice from National Headquarters as required. With the national implementation of bleach distribution, National Headquarters effectively took a leadership role and, with the assistance of a Working Group, established program standards that provided direction for national implementation.

There is a general consensus, however, that National Headquarters has not taken a similar leadership role to ensure consistent, national implementation of several of the other initiatives. Examples cited were the inmate health promotion modules developed in conjunction with the Ministry of the Attorney General of British Columbia and implemented in Pacific Region. While materials were distributed, there was no implementation plan developed to ensure consistent national implementation nor were the materials translated, to permit implementation in Quebec Region. To date, only two Regions have implemented the model. With respect to the peer education project, piloted at Dorchester Institution in Atlantic Region, staff are waiting for direction and decision from National Headquarters before proceeding to implementation.

Regional staff who managed major projects in support of CSC's National AIDS Program believe that they are responsible for managing the project during the developmental stages. However, they believe that the responsibility for sharing the results with other regions, the development of national standards and guidelines, leadership for national implementation, and establishment of evaluation and monitoring mechanisms to ensure that initiatives are implemented, resides with National Headquarters.

Similarly, Health Services needs to ensure information-sharing with institutional staff. Many institutional respondents to the questionnaire identified the need for greater collaboration and information flow among National Headquarters, the Regions and institutions, and among institutions within their own Regions.

Regional staff involved with the initiative felt that they were reasonably well informed about CSC's activities relating to HIV/AIDS. However, they attributed this to their direct involvement on the Anonymous Testing and Bleach Kit Distribution Working Group.

On the other hand, the dissemination of information and educational materials, and the results of projects and research/developmental activities to institutional staff has been limited.

Institutional staff do not feel that they are particularly well informed of initiatives and activities related to HIV/AIDS being undertaken by CSC under NAS-II, nor did they feel that National Headquarters was responsive to their needs (73%). The majority of respondents (80%) reported not being informed about the activities or initiatives being undertaken in regions other than their own. Generally, the institutions rated Health Services poorly in the area of effectiveness of collaboration and consensus seeking.

Many health services staff indicated that they could benefit from receiving additional information. Staff value the opportunity to exchange ideas and to receive updates/discuss projects and experiences. Institutional respondents felt it would be beneficial for the institutions to share best practices related to their own implementation initiatives.

It is apparent that responsibility for information dissemination to the institutions is not clearly defined. Health Services at National Headquarters view this as a regional responsibility. Health Services, National Headquarters, by virtue of their links to Health Canada resources and national professional associations should remain the focal point for the collection of relevant information, however, they should initiate discussion with the Regions to determine the most appropriate mechanisms for disseminating information to ensure that it reaches the operational level

There was also an expressed need for more professional administrative support from Regional and National Headquarters. Institutional nursing managers identified the need for administrative advice and backup, particularly to obtain information on standards of care, latest treatment protocols for HIV/AIDS, legal and ethical issues, and exposure protocols for staff.

As the results of pilot and research projects become available, CSC's communication role should be expanded to ensure that CSC staff, as well as other jurisdictions and professionals in the field of HIV/AIDS research are informed of the findings and can benefit from CSC's experience.

The majority of institutional staff offered suggestions for the improvement of communication and collaboration between all levels of the organization: Several indicated that line staff should be consulted by National Headquarters for their opinions and feedback. Others suggested that regional committees should be established with representation from each institution.

Some anecdotal comments are provided below:

> *"Professional input from the field by having institutional staff sit on national planning/strategy committees."*
>
> *"Participation of our staff in programs already in place in other institutions to facilitate implementation in our facility."*
>
> *"When projects are being developed, staff should be asked for feedback rather than having packages delivered after the fact and then told to implement them."*
>
> *"Ask for input, come out to the institutions to discuss new initiatives with health services staff. Talk to the "grassroots" nurse who deal with the prison population."*
>
> *"Each institution should have an HIV/AIDS program; regular contact with National Headquarters and Regional Management Committee; education and resources; current treatment and therapy."*

RECOMMENDATION FOUR:

To improve information-sharing between all levels:

- **Health Services, National Headquarters, in consultation with the Regions, should clarify responsibility for information-sharing with institutional staff, and determine mechanisms to inform staff, and others, on a regular basis, of CSC activities in the area of HIV/AIDS e.g. Bulletins, regular meetings of coordinators; and,**
- **That Health Services at National Headquarters table the information sharing issue as an agenda item at any future Health Care conference.**

The current National HIV/AIDS Coordinator has established informal links with various Sectors at Health Canada, the main partner in NAS-II. She is a member of the AIDS Coordinators Committee, chaired by Health Canada. It has been noted that these meetings provide little information relevant to CSC, possibly because CSC is an operational agency compared to most of the other participants who are policy, and research oriented.

Additionally the National HIV/AIDS Coordinator liaises with a various other Health Canada committees, the Department of Justice, provincial public health and provincial and territorial corrections.

Recently, a Federal, Provincial, Territorial Heads of Corrections Working Group on HIV/AIDS has been established with a mandate to promote the policy and program environment that will enable collaborative effort on the part of federal/provincial/territorial corrections jurisdictions to address HIV/AIDS.

The Correctional Service and Health Canada has given tangible recognition to the importance of community-based support through the participation of community agencies in various initiatives. Specific initiatives involving such external partnerships include:

- funding to the Kingston AIDS Project; a community-based group which provides information, counseling and support to offenders in federal prisons in the Kingston area.
- funding support for the First National HIV/AIDS in Prisons Workshop, sponsored by the Prisoners with AIDS Support and Action Network (PASAN). Working with this group, as members of the planning committee proved difficult for both CSC and Health Canada.
- involvement of community-based organizations in the development and delivery of several major initiatives. The most significant was the participation of AIDS New Brunswick in the development of the pilot inmate peer education program at Dorchester Institution. Other partnerships included the participation of AIDS Vancouver on the Steering Committee of the Matsqui bleach distribution pilot, and assistance provided by the British Columbia Centre for Excellence in HIV/AIDS in the development of the evaluation questionnaires for the pilot.

At the National level, promotion and liaison with community groups such as the Canadian AIDS Society and the Canadian HIV/AIDS Legal Network, has been quite successful, however, that success has also meant that some community groups such as PASAN have looked to CSC for action, commitment and advancement on the ECAP recommendations in relation to the transmission of HIV/AIDS in federal prisons.

The development of partnerships with community based organizations at the institutional level has been less successful. The majority of institutional staff indicated that community services or AIDS organizations were infrequent partners in the delivery of education or in providing care, treatment and support to inmates.

More specifically, the public health services or community based AIDS service organizations were involved in the delivery of education to inmates in 22% and 37% of responding institutions respectively. Pre and post-test counseling involved community AIDS organizations in 26% of the responding institutions. Inmates who are diagnosed as being HIV positive are referred to community AIDS organizations and social/health service organizations in 52% and 26% respectively.

Some operational units reported that it is difficult to establish such relationships due to the lack of local services, or the remoteness of the institution from major urban centres that can provide HIV/AIDS services. Additionally, staff reported that developing such relationships is often time consuming, and given that institutions do not have dedicated resources for infectious diseases/HIV/AIDS programming the establishment of these links must be assumed within existing job responsibilities.

Some staff found it difficult to work with community-based agencies since some of these groups can be highly proactive in promoting individual, sometimes controversial, treatment approaches whose efficacy may not have been established in the medical community. While community agencies come into many institutions on a volunteer basis to provide one on one support to inmates living with HIV/AIDS, the delivery of education sessions on a periodic basis is generally contracted. Therefore, the costs of delivery of periodic education sessions by external organizations may be prohibitive and may deter some institutions from using such sources.

There is a real potential for improved "quality of service" to offenders living with HIV/AIDS as well as opportunity to use the knowledge and services of provincial and community-based agencies to educate staff and inmates about AIDS and protective measures. In addition, the links established with these services while the inmate is incarcerated improves access to services upon the inmate's release.

RECOMMENDATION FIVE:
That a role statement be developed for the Regional and Institutional AIDS Coordinators, and that it include the requirement to actively promote community-based partnerships in the delivery of training and other services to inmates.

Transferability of Pilot Results:

Lessons were also learned from the implementation of specific initiatives based on the experience of pilots. The selection of pilot sites for "testing" or developing the models for new initiatives raises some interesting issues with respect to transferability of results of pilots to other institutions.

The national program model for bleach distribution, for example, is based on the pilot project at Matsqui Institution in British Columbia.

Matsqui was chosen for various reasons: support from the warden and staff, as well as members of the inmate committee; the close at hand experience with bleach in the provincial correctional system; the fact that bleach had been available to offenders for some time through the laundry; and the extensive education that had already been done by both staff and the inmate group, Prisoners HIV Support Group. This group has become very knowledgeable about HIV/AIDS and has been instrumental in providing education, counseling, ensuring condoms are available in the institution, and when bleach distribution was introduced, for the handing out of the kits and refills. In effect, many of the elements for successful implementation were already in place at Matsqui Institution.

The initiative got underway in December 1994 with the appointment of a full time institutional project coordinator. Although the project was initiated in December 1994, the bleach kits were only distributed to inmates at the beginning of June, 1995. The intervening months were devoted to educating inmates and staff, designing the program and addressing staff safety concerns. Strategies to promote the pilot and underline the importance of harm reduction strategies included meeting with all staff, holding a one day information fair, and inviting an inspector from Labor Canada to assess the project from a safety perspective.

The coordinator was supported by an institutional working group made up of ten staff members including the coordinator, four inmates, and the prison outreach worker from AIDS Vancouver. It included a research/evaluation strategy, that involved the distribution of questionnaires, developed with the assistance of the British Columbia Centre for Excellence in AIDS, to track participation, use and impact on needle cleaning behaviour.

The preliminary results of the Matsqui pilot were highly favorable and as a result, CSC's Executive Committee, at its April 1995 meeting and with the Minister's support, ratified the decision to introduce bleach distribution and anonymous HIV testing in all CSC institutions. This decision to proceed with bleach distribution was made without the benefit of a formal evaluation of the pilot at Matsqui Institution.

Executive Committee also directed that CSC develop an implementation strategy for both bleach kit distribution and anonymous testing[23]. Health Services established an national working group, comprised of the National HIV/AIDS Coordinator, and a representative from each Region. The Working Group consulted extensively with the two main unions USGE and PIPS.

---

[23] The anonymous testing program will be reported on separately.

The Working Group was responsible for the development of national guidelines, consideration of regional differences and union concerns, and the establishment of a progress reporting mechanism to ensure accountability.

The bleach kit distribution program was targeted for implementation by September 30, 1996. It is noted that the guidelines are dated April 1996, suggesting that the timelines between completion of the guidelines and the implementation date was, at most, 6 months.

A common pitfall with pilot projects that lead to national implementation is the failure to provide equivalent levels of resourcing and support as provided to the pilot to ensure its success.

Several respondents observed that there was an assumption that the success at Matsqui would be repeated at all operational sites. In interviews and in response to the questionnaire, staff indicated that conditions for implementation were often less favorable in some of the other institutions. There were different implementation barriers among the security levels, less management and staff support at some institutions, and fewer resources and tools (lead time for education, a dedicated resource knowledgeable about HIV/AIDS, responsible for implementation, etc.) than had been provided to Matsqui to guarantee the success of the pilot.

Pilots provide valuable information on how best to approach innovative but controversial programs, and assist in the identification of potential problems enabling their resolution before national implementation. However, the selection of a pilot site with exceptionally favorable precursors to successful implementation will not necessarily provide information on how likely the program will succeed at other sites, particularly if the operational units are not provided levels of resourcing similar to that which was provided to the pilot.

RECOMMENDATION SIX:

That Health Services carefully assess the transferability of pilot results to each operational unit before proceeding with national implementation.

Inconsistent Implementation.

In several areas, a national standard has not been developed and therefore initiatives have been inconsistently implemented by the operational units. This evaluation reports on the most significant of these: the requirements for inmate and staff education and the availability of protective measures for inmates, more specially, condoms, dental dams and lubricants. This issue is directly related to the issue of monitoring implementation, which is discussed at a latter point in this report.

Inmate education:

Education of inmates about HIV/AIDS is the most important effort that can be made to promote and protect their health.

In response to ECAP, CSC agreed to build on and improve educational programs already in place by:

- emphasizing HIV/AIDS education on entry and on a regular basis during incarceration; and
- encouraging and supporting community based AIDS, health or prisoner groups to provide education sessions.

CSC policy (Commissioner's Directive 821) requires Regions to develop and coordinate a comprehensive education effort for inmates, as well as for correctional staff. Education and training is to be provided at reception with periodic updates during incarceration to ensure that offenders are kept informed of developments. While not explicitly stated in current policy, operational units are encouraged to engage various external groups such as community-based agencies or inmate support groups (e.g. Prisoners With AIDS (PWA)), to help provide effective program and prevention strategies.

Health promotion/infectious diseases education activities are accepted as effective strategies in health care delivery and should be adequately funded at each institution. Consistent with Health Service's shift toward health promotion and disease prevention, and the Standards for Health Care, National Headquarters has developed, or funded the development through NAS-II, a number of training materials to assist nursing staff in delivering health education and promotion programs in their institutions (Finding Out, Choosing Health In Prisons).

Interviews with regional staff, and the institutional staff questionnaire confirmed that while education opportunities are generally available to inmates-(85%) the delivery of education sessions varies considerably among operational units in terms of how frequently HIV/AIDS education is provided and who delivers the education sessions. There is considerable variation in the interpretation of "periodic updates" and in the extent to which partnerships with community-based AIDS or health agencies or prisoner's groups have been developed to assist in providing education. Several sites reported having peer education initiatives. Pamphlets and other literature were identified by all respondents as being available to inmates.

The frequency of training sessions varied. Only one respondent indicated that the inmate received training prior to release to the community. In most cases the education sessions are delivered by health services staff. About 37% respondents reported involving local community-based AIDS organizations in training. Local health and social service agencies participated even less frequently.

While National Headquarters encourages operational units to use the tools that have been developed for inmate education purposes, there is no national standard in place to ensure consistency in inmate education, and no mechanisms in place to monitor what training does occur and what resources are being used to deliver the training.

Lack of Inmate interest in HIV/AIDS education was identified by some as a potential factor in the ability to identify and deliver formal infectious diseases sessions. Several respondents reported having to cancel sessions they had organized with external experts due to lack of participation. Staff reported that inmates will attend sessions, only if they are personally impacted by HIV/AIDS.

The method of delivery is therefore a significant factor in successful inmate education. Peer education program shows promise as an effective educational delivery mechanism but it has yet to be implemented nationally. CSC has committed in its 1997/98 plan to resource the adaptation and implementation of the Dorchester Peer Education or similar program, for national implementation this fiscal year, as well as to meet the needs of women and Aboriginal inmates. Regions are anxious to commence with this initiative as the majority of respondents see a dire need for additional inmate education in the area of HIV/AIDS prevention and the absence of a nationally consistent standard for inmate education as a major weakness of the National AIDS Program.

The development of a nationally consistent inmate education program is of paramount importance as it forms the foundation for effective prevention efforts.

RECOMMENDATION SEVEN:

With respect to inmate education:

That Health Services, National Headquarters develop a nationally consistent standard for inmate education/refresher to define, more precisely, the term "periodically."

To ensure that the momentum created by the pilot at Dorchester Institution not be lost, that health services at National Headquarters move quickly to develop a minimum national standard for the delivery of peer education.

Staff education:

In CSC, staff training and the development of policies and protocols to ensure workplace safety are the responsibility of CSC's Personnel and Training Sector. Health Canada will assist federal departments in providing training to federal employees in the area of workplace exposures and protective measures, upon initiation by the department.

CSC policy requires that staff receive education and training on infectious diseases and substance abuse as part of their orientation, and periodically thereafter. In particular, staff are provided education on substance abuse and harm reduction, universal precautions and protective measures in the workplace, what constitutes a significant exposure and what to do in the event of exposure. In responding to ECAP, CSC committed to:

- building on and improving current HIV/AIDS education programs during orientation and regularly thereafter;
- providing staff with the protective equipment and procedural training to enable them to protect themselves from all infectious diseases; and,
- working closely with Health Canada to provide thorough follow-up in the event of exposure to blood or body fluids.

All new recruits receive training in infectious diseases as part of the correctional training program (CTP). This module has been available since 1991. It has been designed so that it can be delivered in either a one day or 1/2 day session. The trainers have the option to use two videos entitled AIDS - Prison and Hep B - Prison. The delivery of these modules may include input from community organizations and inmates.

CSC policy requires that periodic refresher training on infectious diseases be provided to staff. While most institutions reported that periodic refresher training was provided, the frequency of delivery varied considerably. Of note, however, is that 27% of those responding indicated that refresher training is not being provided to staff in their institutions.

Training is delivered by CSC resources in some regions and by Health Canada in others. Local community-based agency involvement in educating and training of staff was reported as minimal. Of note is that 41% of the responding institutions reported that Health Services staff provide the refresher education sessions to institutional staff. The delivery of services to staff is outside the mandated role of Health Services and has resource implications for Health Services. Accountability for the delivery of education sessions to staff should be examined, and clarified. If determined that this responsibility should reside with health service staff, Health Services should be provided resources accordingly.

Institutional staff reported (54%) that CSC's activities under NAS-II had not increased education and training opportunities for staff. Staff consistently identified the need for education as critical to the successful implementation of CSC's AIDS Program. Some Health Services staff reported that fear still persists due to lack of knowledge. It was suggested that staff "are less educated about HIV/AIDS than the inmates."

Staff surveys conducted in March 1994 and again in 1996, asked whether staff felt that they had sufficient training on preventing the transmission of HIV/AIDS. The results were the same for both surveys: 68% of employed in institutional and community operations felt that they had sufficient education/training. However, as one individual noted, "We have a lot of people who feel they have had enough training, however, these same people still ask what to do if attacked with urine." Some suggested that without appropriately educated staff, and a shift in attitudes, that CSC would not be able to move the HIV/AIDS agenda forward successfully.

Staff reported a range of difficulties associated with the effective delivery of training on HIV/AIDS and more generally infectious diseases. These problems are not unique to the area of infectious diseases, but are problematic within the Service generally due to numerous training demands as well as the high overtime costs associated with relieving staff from duty.

According to the National Course Standards,[24] training in infectious diseases is mandatory, that is, according to the definition of mandatory contained in the Standards, CSC must complete the training to the extent that it does not incur overtime costs. The mandatory, as opposed to essential nature of refresher training is perhaps the most significant impediment to the delivery of training. With the emphasis on meeting overtime targets, there has been a reluctance to provide training when it is stacked up with all the other mandated training that is on the table at any given point in time.

---

[24] Correctional Service of Canada. National Course Standards. 1991.

Since January 1993, Health Canada nurses from regional offices across Canada have been available to deliver training on infectious diseases to all staff who have contact with offenders. Participation has varied for a variety of reasons; but mainly due to an inability of institutions to release staff for training

There is considerable regional variation in satisfaction with the services provided by Health Canada. Some regions report that Health Canada has been fully cooperative in scheduling and delivering the training. In other Regions, Health Canada was a less effective resource for the delivery of this program for two main reasons:

- Health Canada does not necessarily have trainers who are qualified to deliver the modules in a form that is relevant to correctional staff and in the context of their work environment; and,
- lack of coordinated effort by Health Canada and CSC at the local levels.
-

A problem has also been encountered at some sites where education sessions have been arranged and CSC staff have not participated resulting in sessions being canceled. The Personnel and Training Sector is presently working with Health Canada to develop a training module tailored to CSC employees.

RECOMMENDATION EIGHT:

With respect to staff education:

That the Personnel and Training Sector give consideration to modifying the national course standard in relation to infectious diseases to make staff refresher education an essential annual requirement.

That accountability for the delivery of refresher staff education be clearly defined, and the most appropriate delivery mechanisms identified.

Professional Staff Training:

Health Services staff has been provided with tools to assist them in addressing HIV/AIDS, such as the HIV Pre-Post Test Counseling Checklists, as well a number of educational programs for inmates which have also served to increase their awareness of the importance of voluntary HIV testing.

The majority of nursing respondents ((73%) indicated that they had not received specialized training on HIV/AIDS. Those that did report having participated in professional development activities as attendance at seminars and lectures and regional conferences reported that they found that this training enhanced their ability to care for and treat inmates living with HIV/AIDS.

CSC has not invested in their nurses by providing professional development opportunities to enhance CSC's ability to effectively provide services to HIV/AIDS inmates.

Staff identified professional development as a need. When respondents were asked to identify their specific professional development needs, the most frequently identified needs were in the areas of:

- pre and post test counseling;
- providing care, treatment and support to HIV/AIDS offenders;
- how to educate offenders in prevention;
- palliative care;
- clinical information on such items as indications for the utilization and monitoring of protease inhibitors, updates on viral load testing vs. CD4 counts;
- regular updates on new treatments for HIV/AIDS, research on these treatments and results; and,
- management of exposures to HIV.

Staff also expressed the need for greater funding support to attend annual conferences, workshops and seminars specifically HIV/AIDS related. Staff also felt that a professional video for staff, and training provided by a qualified AIDS trainer would be helpful.

Staff also felt that they could benefit from each others experience and that there should be greater communication among facilities. It was suggested that forums be created to exchange information on best practices among facilities.

RECOMMENDATION NINE:

That, the Personnel and Training Sector, in consultation with Health Services, assess the professional development needs of Health Services staff.

That, on the basis of the identified needs, Personnel and Training in collaboration with Health Services, determine appropriate delivery mechanisms for education/ training of health services professionals.

Condom Distribution:

The interpretation and implementation of the policy respecting condoms, lubricant and dental dams, i.e. that they dental dams available in three discreet locations in each institution appears to be inconsistent across Regions. However, as will be discussed later in this chapter, there are no mechanisms in place to monitor compliance with this or other policies so that corrective action is taken as necessary.

Adequacy of Resources:

CSC was allocated $400,000 annually under NAS-II. However, due to lapsed funds in previous years, this was reduced to $300,000 for 1996/97.

Given the scope of work that CSC has yet to do to respond effectively to ECAP, the current funding allocation appears insufficient. CSC, as an operational agency must not only develop national programs and services to respond to HIV/AIDS but must also ensure that these programs and services are implemented in all operational units across the country.

CSC lapsed funds early in the initiative. This was due, in part, to an inability to move issues and implementation forward as quickly as planned due to turnover in CSC Health Services management staff, as well as a six month period in which the position of National HIV/AIDS Coordinator remained vacant. Another factor that contributed to the lapsed funds was the Service's failure to establish a multi-disciplinary response to HIV/AIDS. The activities and funds supported by NAS-II resources remained exclusively in the domain of Health Services and were not disseminated to other National Headquarters sectors or the Regions for HIV/AIDS-related programming.

CSC receives its funding from the Prevention and Community Action Programs (PCAP), Health Canada. PCAP provides support for national education and prevention strategies aimed at groups most vulnerable to HIV/AIDS.
The funding arrangement with Health Canada introduces some impediments to CSC's ability to plan and implement its initiatives. PCAP allocates the funds to CSC on a quarterly basis and requires a progress report and detailed work plan outlining activities for the next quarter before it releases funds. PCAP also approves the projects and activities to ensure they are in line with their education/ prevention priorities. Furthermore, the current National HIV/AIDS Coordinator indicates that PCAP expects the funds to be used primarily for developmental activities and that it has not in the past released funds to support implementation.

The control exercised by PCAP over the activities CSC can pursue with the funds allocated to it contributes to difficulties in planning. CSC does not have the flexibility to reallocate resources between projects when there is a change in plans without consultation with PCAP and agreement to do so. In any future iterations of NAS, CSC should consider negotiating greater control over funds and their allocation.

RECOMMENDATION TEN:

In the event of a renewal of NAS, that CSC negotiate their own allocation of resources under the initiative.

Additionally, at a time of significant budgetary cutbacks within CSC generally, Health Services, National Headquarters was able to undertake significant developmental work in the area of HIV/AIDS due to the availability of funding from an external source. However, institutions were not provided with similar resources, nor were health care centre budgets increased, to support implementation of the new National Headquarters initiatives, or to enhance program and service delivery. Consequently, while the developmental activities undertaken by National Headquarters (e.g. Bleach Kit distribution) have to be operationalized, institutional staff generally report that they lacked sufficient financial and person year resources to effectively implement. Additionally staff report that they have no resources to further advance or intensify their activities on priority areas to respond to HIV/AIDS.

Implementation costs had to be absorbed by regions/institutions and therefore were in direct competition with other organizational priorities. Institutional respondents generally identified that the lack of financial and person year resources as impacting most significantly on the availability of nursing resources to carry out education and health promotion activities.

The ability to undertake additional HIV/AIDS activities at the institutional level in the absence of additional funding was raised by many operational staff and is an issue that cannot be ignored. The general consensus is that there are inadequate person years and dollars at the institutional level to fully implement the current initiatives being developed by National Headquarters under the National AIDS Program and additional initiatives are not sustainable. The following represent some of the compelling comments from operational staff:

> *Resource allocation needs to be a top priority if HIV/AIDS implementation strategies are going to be effective.*
>
> *I have not received additional budget to assure the care of patients with HIV/AIDS.*
>
> *Although there has been direction, there hasn't been enough dollar and human resources support. The issue is only important to Correctional Operations when there is a staff safety concern.*
>
> *I don't know what the answers are. I know this is something that we need to continue to work on. Perhaps our moneys would be better spent with education, education, education and focus remaining money on research into treatments that are effective in reducing the viral loads.*
>
> *The warden recently cut funding from health services thus removing the full time PY dedicated to Health promotion/infectious diseases. This is a real concern given how necessary it has proven to be since our outbreak one year ago.*

Inadequate resources at the operational level is a potential, significant impediment to successful implementation. Health Services should undertake to assess whether resources are adequate for operational units to fully implement the activities under the National AIDS Program.

RECOMMENDATION ELEVEN:

That Health Services initiate an assessment of the impact of the elements of the National AIDS Program on operational units, including an assessment of resources required to ensure full implementation and, if necessary, examine options to ensure implementation is resourced.

While the funding is time-limited, staff were generally of the opinion that the care, treatment and support component of CSC's program would not be affected by a reduction in the federal role or expenditures because activities in this area are within the mandate of Health Services under the CCRA and Mission. Expenditures associated with the developmental components of the program, however, are seen as extremely high, and CSC still has considerable work to do in this area (e.g. needle exchange, methadone maintenance, implementation of peer education). Respondents were generally of the view that CSC's ability to carry out future developmental activities would be hampered by reduced funding support.

CSC is in the process of determining the cost requirements to continue with HIV/AIDS programming beyond 1997/98. Estimates for future funding will be incorporated into CSC's planning submission to Treasury Board - the National Capital Accommodation and Operations Plan. As health is one of three priorities for Treasury Board, it is anticipated that there will be support for the continuation of the program.

Monitoring and Evaluating the Implementation of the National AIDS Program:

Health Services should put into place management controls or mechanisms to gather information to monitor compliance with the implementation of policies relating to implementation of the National AIDS Program, and equally important, to effectively manage the issue of HIV/AIDS. Information is necessary for the purposes of setting priorities, and planning, targeting and implementing the strategy. In the absence of such mechanisms, the necessary information to guide the strategy and to identify inconsistencies or non-compliance with policy does not exist and there is no accountability, and no capacity to evaluate how well and effectively NAS-II achieved its objectives.

The Service's Mission, Core Value #5 and related strategic objectives and guiding principles highlight the importance for CSC of being accountable for its activities and ensuring sound resource management. In keeping with Core Value #5 and its commitment to accountability, the Service subscribes to current management theory and directives of central agencies which increasingly stress the necessity of management controls and effective monitoring systems for any result-driven and client oriented organization. In this regard, the evaluation examined whether appropriate information collection and monitoring mechanisms exist to effectively manage the program and to measure performance. It also followed up on the observations of the mid-term review to determine if the concerns respecting the availability of information for the purposes of the final evaluation had been addressed.

Data on Incidence of HIV/AIDS:

The mid-term review noted that the Service only collects data on reported cases of HIV/AIDS and that these data do not provide accurate statistics on the magnitude of the HIV/AIDS problem. These statistics are considered to provide an underestimate of the actual number of cases. Ad-hoc seroprevalence studies of prison populations suggest that the incidence may be as much as ten times higher than in the general population. Furthermore, these data do not provide "case-specific" information on the characteristics of the infected population, including risk behaviours.

The mid-term review also noted that it has been identified by outside observers, such as ECAP that "ad-hoc information-gathering exercises are needed to indicate the extent to which the number of reported cases is an accurate measure of the CSC situation."

The issues raised in the mid-term review in relation to the collection of HIV/AIDS data are under discussion. The accuracy of the reporting of HIV/AIDS case in CSC facilities is suspect. Institutional staff indicated that their are no written guidelines on how they are to distinguish AIDS cases from HIV positive cases. For instance, it is unclear if staff have been directed to use a standard definition, such as that used by the Laboratory Centre for Disease Control, or the United States Centre for Disease Control, to distinguish HIV from AIDS cases. Furthermore, the data being collected are of minimal utility because they simply report cases of HIV/AIDS and provides no case-specific information about the offender's risk behaviour. Additional data, such as risk behaviours and demographic information, would provide additional insights into HIV/AIDS in correctional institutions.

CSC has recently initiated discussions with its Research Branch and the Laboratory Centre for Disease Control (LCDC) at Health Canada to explore the feasibility of conducting a major seroprevalence study to define the incidence of HIV/AIDS within its institutions and the extent of high risk behaviours.

CSC has initiated, in consultation with Health Canada and CSC systems staff, the development of a data base to collect case-specific data on tuberculosis. A similar system for HIV/AIDS may be envisaged. However, until such a system is fully operational, Health Services should ensure that staff are reporting consistently on HIV/AIDS. This consistency could be facilitated by ensuring that staff are all provided with and using the same clinical definition of HIV/AIDS.

Project Monitoring and Evaluation:

CSC has not instituted mechanisms to routinely or consistently collect data on the implementation of new programs, on routine HIV/AIDS-related programs and activities, or more importantly, on the nature and cost associated with clinical interventions for HIV/AIDS cases. Consequently, there is no national system in place that offers good operational statistics, data for evaluation purposes or for strategic decision-making.

To be in a position to respond to the Minister, Parliament, the Commissioner, central agencies, its critics and ultimately the public on activities, expenditures and performance in the area of HIV/AIDS, the Service should have information on the program's operations both as a whole and with respect to each region. This assumes a degree of standardization in the quality and level of service being provided, an issue that will be addressed under impacts and effects later in this chapter.

To ensure that information is available to management on actual performance in terms of efficiency, economy and effectiveness, plans should be made to identify key aspects of the Program, develop performance standards and collect information on these standards, (operations, services and costs). Such information will provide a regional and national overview of activities, practices, and expenditures relating to HIV/AIDS, and is necessary to monitor the quality and level of service being provided, effectively manage the program, report on compliance, show regional particularities, identify deficiencies or gaps in the program and measure performance and effectiveness.

RECOMMENDATION TWELVE:

That National Headquarters Health Services, in consultation with the Regions, identify the information critical to the on-going management and evaluation of CSC's National AIDS Program, its operations, services and costs, and develop the necessary information collection mechanisms, management controls and monitoring tools to collect this information.

When establishing new national programs, Health Services should include in plans, the development of tools to monitor compliance, and establish mechanisms to identify and collect information or key performance indicators that will enable evaluation of the program's success. CSC, overall, has not given enough attention, during the initial stages of program development, to developing a research and program effectiveness evaluation framework that would enable the assessment of the impact and effectiveness of its National AIDS Program at a later date. For instance, there is no framework to collect data for the evaluation of some of the major components of its strategy, such as, inmate and staff education, and condom distribution. Again, a weakness in the national bleach distribution program is that a research and effectiveness evaluation component was not contemplated in the program development so no evaluation framework was developed and no on-going data collection instituted on participation, or characteristics of participants behaviour/change in behaviour to support future evaluation.

Overall, CSC does not appear to have given enough importance to the effectiveness evaluation and research components of its initiatives.

A retrospective development of an evaluation framework increases the difficulty of collecting data on behaviours before the national implementation of the program. It is therefore more difficult to draw a comparison between pre and post implementation, attribute behaviour change to the program and draw conclusions on effectiveness. Efforts in this area will have to be further expanded to broaden CSC's knowledge base of the effectiveness of various components of its AIDS program.

Two of CSC's pilot projects were particularly well managed and the monitoring and evaluation mechanisms worthy of note. These are the Inmate Peer Education pilot project, developed under contract with AIDS New Brunswick and the pilot of the bleach kit distribution program at Matsqui, managed by an employee of the Service.

CSC's contractual agreement with AIDS New Brunswick specified contractual reporting requirements and review processes. The Coordinator of the bleach distribution pilot is a CSC employee and reported directly to the warden of Matsqui Institution.

Accountability frameworks were established for both pilots. Each had a project coordinator devoted to the project on a full-time basis, with clearly defined roles and responsibilities. Both pilots were also supported by Multi-disciplinary committees.

The project coordinator for the Inmate Peer Education Pilot worked with a national advisory committee consisting of broad representation from including the CSC National HIV/AIDS Coordinator, other CSC staff, and Health Canada as well as from the John Howard society, various community-based AIDS service organizations, persons living with HIV/AIDS, inmates, as well as individuals and organizations across Canada with experience working in a prison setting. The committee had primarily a consultative role, providing input and consultation on various phases of the project. A Dorchester sub-committee was formed and included representation from Health Care, Case Management, Psychology, Personal Development, security, and inmates. Inmates played a significant advisory role throughout the project.

The coordinator of the bleach kit distribution pilot established a steering committee of inmates, security staff, a member of the institutional emergency response team, a representative from AIDS Vancouver. The files indicate that the Coordinator provided regular progress reports directly to the Warden and to the National HIV/AIDS Coordinator at National Headquarters.

In general terms, these Committees were mandated to oversee the development and implementation of the projects, find solutions to operational and administrative issues and problems, oversee the development of policy, educational and other documents related to implementation (e.g. Education Package-National Bleach Kit Distribution Program, April 1996, National Guidelines for Bleach Distribution).

The assignment of a project coordinator ensured accountability for the project and for regular reporting on the progress of the projects. The Committees also served to ensure that information about the project is shared.

Health Services has recognized the need for monitoring and tracking mechanisms to assess the progress of the initiative. A component of the recently developed national program strategy is the requirement that all components of the strategy be accompanied by a project plan with milestones against which the projects will be tracked and monitored.

Another aspect of the bleach and peer education pilots that contributed to their success was the fact that each included an evaluation strategy. The evaluation plan was built into the contract and project plan for the inmate peer education pilot.

The evaluation of the program was completed through the administration of a knowledge, attitudes and behaviour questionnaire administered prior to and three months following the implementation of the peer-led group that assessed the impact of the Peer Education Program on the HIV-related knowledge, attitudes and behaviours of the inmates at Dorchester.

An evaluation component was also built into the Matsqui Pilot. With the assistance of the British Columbia Centre of Excellence in AIDS, the Coordinator developed an inmate and staff questionnaire which was distributed prior to the distribution of bleach. Six months after the initial questionnaire, a second questionnaire was distributed. The results of both questionnaires were analyzed by the B.C. Centre.

In both pilots the project development process included the development of an evaluation strategy and therefore assured the gathering of information to measure participant characteristics and behaviour prior to the commencement of the pilot, while participating in the pilot, and upon conclusion of the pilot.

RECOMMENDATION THIRTEEN:

That Health Services, National Headquarters strengthen efforts to develop and implement research and evaluation frameworks for HIV/AIDS programs to ensure a consistent approach to program and project monitoring and reporting. This should include effectiveness evaluation and data on achievement of project/program objectives commensurate with the size and complexity of the individual projects/program.

Summary and Conclusions - Implementation and Objectives Achievement:

The objective of CSC under NAS-II was to implement some of the ECAP recommendations, thus contributing to the goals of NAS-II. This objective has been modified in February 1997 to reflect a shift in focus and objectives to the development of an integrated, multi-disciplinary program. Since this shift is so recent, it is too soon to attribute impacts on achievement of the objectives of NAS-II to this change in focus.

At the time of the mid-term review the momentum of the CSC's response to ECAP had slowed down. The review identified a number of problem areas which needed to be resolved in order to ensure successful implementation. This evaluation has found that CSC is taking some important first steps to address the problem areas identified in the mid-term review.

CSC has made progress in addressing the deficiencies raised in the mid-term review and, more recently, in the Jurgens Report. The most significant are:

- the development of an integrated, multi-disciplinary program framework that address the ECAP/Jurgens recommendation and establishes an HIV/AIDS program that involves a contribution from all Sectors of CSC;
- establishment of various committees to move the HIV/AIDS agenda forward in CSC. Members are responsible for overall implementation of the program. Specific committees have been established to address particular initiatives. These Committees also enhance inter-regional and inter-sector coordination and collaboration on HIV/AIDS issues;
- clearly defined accountabilities for administration of the program at the regional and local levels;
- detailed plans of action to address the identified deficiencies in the CSC response to HIV/AIDS.

Now that it has a framework in place, CSC will be better positioned to deal with the issues raised by ECAP and the Jurgens Report.

Despite the weakness identified in CSC's response to HIV/AIDS, there have been successes in CSC's participation in NAS-II. Institutional staff report that the initiative gave HIV/AIDS in prisons a higher profile, increased knowledge about HIV/AIDS in prisons, and increased CSC's attention and staff awareness to HIV/AIDS. Staff also reported that NAS-II had enhanced CSC's capability to deliver programs and services.

Health Service staff reported that there had been little impact on care, treatment and support. It was their view that CSC is mandated to provide health care and treatment, therefore activities in this area would have occurred irrespective of the National AIDS Program.

CSC has also made substantial progress in the area of policy and program development. Condoms, dental dams and water-based lubricant are available to inmates. In terms of preventing the spread of HIV/AIDS, the national implementation of bleach kit distribution following a successful pilot at Matsqui Institution, was a significant contribution to the availability of harm reduction measures for inmates. CSC must establish monitoring and evaluation mechanisms that will enable it to assess whether a program has been fully implemented and how well it is doing. For instance, the effectiveness of bleach distribution is not known; an evaluation of the program is planned for later this year.

It is important to recognize the limits of harm reduction and prevention measures in terms of the impact on inmate behaviour, as well as the extent to which such measures will be taken by inmates within a correctional setting. Drug use is an illicit activity, therefore clandestine use is the norm and offenders often do not take the time to take the necessary precautions.

While prevention measures are an important step, it is important to provide on-going education and training so that inmates will be aware of and use such measures effectively. In this area, CSC has developed several tools for staff use when delivering education and training to inmates. In this area as well, CSC has developed a model peer education program. It has yet to be implemented nationally.

CSC is building on the work that has already been done under NAS-II and has proceeded to make plans to examine further harm reduction measures such as needle exchange, methadone, and tattoo equipment in institutions; to develop and deliver education and training to inmates and staff; to strengthen its policy direction in key areas such as sharing of HIV/AIDS-related information and confidentiality; to encourage testing and to explore the range of testing options available to inmates; and to standardize requirements in key areas such as treatment, and inmate education

4.3 COST EFFECTIVENESS AND ALTERNATIVES

NAS-II funding effectively increased CSC's capacity to respond to HIV/AIDS. It provided CSC with the resources to focus explicitly on implementing some of the more complex components of the ECAP recommendations. In the absence of NAS-II funds, these components would have competed for resources with other Service priorities and would have developed more slowly, if at all.

NAS-II resources has provided the impetus for National Headquarters to develop major components of the CSC program, however, as elements of the program have evolved beyond the developmental stage, their on-going administration is being sustained by CSC. For example:

- a proportion of NAS-II funds were initially used to staff the position of National HIV/AIDS Coordinator on a secondment basis, however, the National HIV/AIDS Coordinator position is now a dedicated person year within Health Services;
- the distribution of bleach, condoms, dental dams and lubricants is now an integral component of CSC HIV/AIDS programming;

- the educational materials and tools (Finding Out, Health Promotion modules) developed with NAS-II funding now form the basis for HIV/AIDS education for inmates; and,

- the on-going delivery and administration of peer education programs will become an institutional responsibility.

Funding was not allocated to the operational units to support the implementation and delivery of the newly developed programs or services. Nor have health care budgets increased to reflect the additional responsibilities associated with implementation of the initiative. This may have had an adverse impact on the capacity of operational sites to effectively implement some of the initiatives. Should the National AIDS Strategy be renewed, consideration should be given to the allocation of resources to support implementation of new initiatives.

While the funding is time-limited, staff were generally of the view that the requirement to provide services to offenders living with HIV/AIDS, and to prevention initiatives were within the mandate of CSC. It was therefore believed that the level of care, treatment and support should not be dependent upon the funding of NAS-II.

Expenditures associated with the developmental components of the program, however, are seen as extremely high, and CSC still has considerable work to do in this area (e.g. needle exchange, methadone maintenance, implementation of peer education). Continued NAS funding support is an effective way to ensure that CSC will be able to carry out future developmental activities.

Some respondents perceived that the most effective means of addressing HIV/AIDS is to maintain a specific focus so that the efforts are sharply targeted and amenable to assessment in terms of their impact. The alternative view is that HIV/AIDS as one manifestation of the broader problem of the transmission of blood-borne pathogens and are of the view that HIV/AIDS should be subsumed under a broader initiative relating to infectious diseases. Some staff observed that the overriding attention has been on HIV/AIDS, at the expense of an integrated approach to infectious diseases. Staff expressed particular concern about the incidence of Hepatitis C and the fact that this disease warranted greater attention from the Service than it is currently receiving.

CSC is in the process of determining the cost requirements to continue with HIV/AIDS programming beyond 1997/98. It anticipates accessing carry forward funds for this fiscal year. Estimates for future funding will be incorporated into the National Capital, Accommodation and Operations Plan.

As health is one of three priorities for Treasury Board, it is anticipated that there will be support for the continuation of the program.

Summary and Conclusions:

Health Services recognizes that the need for on-going funding is problematic and is seeking funding sources to ensure that funding will be available to carry out the required activities beyond this phase of the initiative. Alternately these activities could be carried over into a renewed initiative which would continue to give the issue prominence and focus. A renewed initiative could contribute to furthering the work underway and planned.